

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 830 01778 214

1. PLACE OF DEATH:

County Montgomery
 City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Maple Lane Nursing Home
9 months

How long in hospital or institution?

3. (a) FULL NAME

FANNIE ADES

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced	
<u>Female</u>	<u>White</u>	<u>Married</u>	
6. (b) Name of husband or wife		<u>Harry Ades</u>	
7. Birth date of deceased (mo. day. yr.)	8. (c) If alive, give age years		
<u>1881</u>			
8. AGE: Years	Months	Days	If less than one day hrs. min.
<u>67</u>	<u>-</u>	<u>-</u>	
9. Birthplace	<u>Russia</u> (Town, county, and state)		
10. Usual occupation	<u>House-wife</u>		
11. Industry or business			
12. Name	<u>Loeb Levine</u>		
13. Birthplace	<u>Russia</u>		
14. Maiden name	<u>Toby</u>		
15. Birthplace	<u>Russia</u>		
16. Informant	<u>Sig Ades</u>		
Address	<u>9700 Marshall Ave, Silver Spring, Md.</u>		
17. Burial (Burial, cremation, or removal, which?)	Date thereof (month) (day) (year) <u>Burial</u> <u>Feb. 29/1948</u>		
Cemetery or crematory	<u>Baltimore Hebrew Cemetery</u>		
Location	<u>Baltimore, Md.</u>		
18. Funeral director	<u>Bernard Abzugsky & Son</u>		
Address	<u>3501-14 38th St. Wash. D.C.</u>		
19. Date rec'd by registrar	<u>Feb 19 1948</u>		
(Date rec'd by registrar)			

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
 Street No. 10,000 Georgia Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1947 to Feb. 19 1948and that I last saw her alive on Feb. 19 1948

Immediate cause of death

Acute intestinal obstruction

DURATION

Due to General debility

Due to

Other conditions Cerebral hemorrhage with
left hemiplegia
(Include pregnancy within 8 months of death)Major findings of operations NoneDate of op. None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

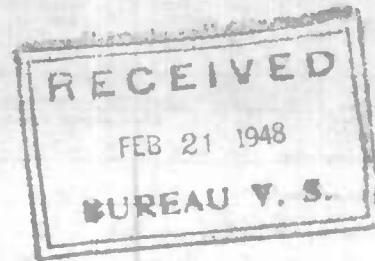
Injured at work?

23. SIGNATURE

Henry J. Lourdes M.D.

M. D. or other

Address 1603 19th St. N.W. Date signed 2/19/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01779

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Eight years

Hospital, institution, or street address where death occurred:

514 Greenwood Ave.

How long in hospital or institution?.....

3. (a) FULL NAME

Mrs. Margaret Louisa

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife.....

John Smith Agnew

7. Birth date of deceased (mo. day, yr.)

December 14, 1858

6. (c) If alive, give age..... years

8. AGE: Years

89

Months

1

Days

22

If less than one day

hrs.

min.

9. Birthplace.....

Emmitsburg, Maryland

(Town, county, and state)

10. Usual occupation.....

House wife

11. Industry or business.....

Home

12. Name.....

Eli Horner

13. Birthplace.....

14. Maiden name.....

Sophia Agnew

15. Birthplace.....

16. Informant.....

Mrs. Dorothy Rife

Address

514 Greenwood Ave., Tak.Pk., Md.

17. Burial, cremation, or removal. Which?.....

Burial

Date thereof.....

Dec 7 48

(month) (day) (year)

Cemetery or trematory.....

EMMITSBURG Cem.

Location.....

EMMITSBURG, MD.

18. Funeral director.....

J.H. Rife & Co

Address

2501, 14th St., Washington, D.C.

19. Date rec'd by Registrar

Feb 15 1948

19 X8

John D. D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

City or town.....

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

514 Greenwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

Agnew

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

February 5, 1948, at 12: A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

September 15, 1947, to Feb. 4, 1948

and that I last saw her alive on February 4, 1948

Immediate cause of death.....

Cardio-vascular disease with generalized edema.

Duration.....

5 mo. +

4 mo.

Due to.....

Arteriosclerosis, generalized and

Due to.....

Hyper tension

years +

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

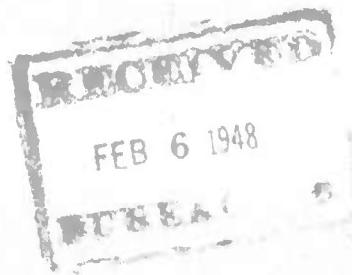
Wallace H. Monk, M.D.

105 Carroll Ave.

Md. or other

Takoma Park, Md. Date signed 2-5-48

Address.....



*Evidence for change
of year of birth shown on*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01780

FILM NO. G 114 FEB 27 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 714

4687

1. PLACE OF DEATH:

Montgomery County

Silver Spring City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

505 Schuyler Road

How long in hospital or institution? None

3. (a) FULL NAME

Lucy Williams Allnutt

3. (b) Social Security Number

None

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife

Joseph N. Allnutt

7. Birth date of deceased (mo., day, yr.)

February 15, 1871 1869

6. (c) If alive, give age 85 years

8. AGE:

77 Years

11 Months

12 Days

If less than one day

..... hrs. min.

9. Birthplace

Poolesville, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

MOTHER FATHER

12. Name Walter Allnutt

13. Birthplace Maryland

14. Maiden name Hester Chiswell

15. Birthplace Maryland

16. Informant Mrs. Lawrence Whittacher

Address Silver Spring, Maryland

17. Burial

Date thereof February 9/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Date of op.

Cemetery or crematory Monocacy Cemetery

Location Bellsville, Maryland

18. Funeral director Wm. L. Anderson

Address Bethesda, Maryland

19. Date rec'd by registrar

19. 46.8

Josephine M. Schaff

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 505 Schuyler Road

(If rural, give LOCATION)

None

2. (a) If veteran, name war.

MEDICAL CERTIFICATION

February 7, 1948 19 9:24 A.M.

20. DATE OF DEATH

Oct. 1946 10 2/7 19 48

and that I last saw her alive on 2/7 19 48

Immediate cause of death

Peritonitis

Due to: Expansion of gall bladder

Carcinoma of gall bladder & liver disease.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

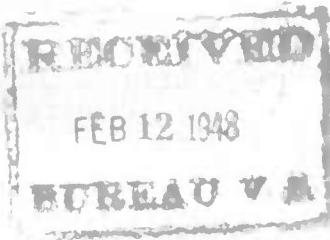
Meane of Injury

Injured at work?

23. SIGNATURE

James T. Beeson, M.D. or other

Address 1835 1/2 Decatur Date signed 2/7/48



M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01781
216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... **Montgomery**City or town..... **Bethesda (rural)**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **2 months, 1 day**

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.How long in hospital or institution?..... **2 months, 1 day**

3. (a) FULL NAME

ANGLIN, Norma Stevens

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

female W-US married6.(b) Name of husband or wife..... **Hugh W. Anglin**7. Birth date of deceased (mo., day, yr.) **October 10, 1921**8. AGE: Years Months Days If less than one day
26 4 17 hrs. min.9. Birthplace..... **Col.**
(Town, county, and state)10. Usual occupation..... **housewife**

11. Industry or business

12. Name..... **STEVENS, Frank dec.**13. Birthplace..... **Mass.**14. Maiden name..... **SULLIVAN, Irene**
15. Birthplace..... **Idaho**16. Informant..... **husband: Lt. (JG) Hugh W. Anglin, USN**Address **3000 Lee Highway, Arlington, Va.**17. (burial) Removal Date thereof..... **Feb. 27, 1948**
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location..... **Colorado Springs, Col.**18. Funeral director..... **S. H. HINES, J.A.C.**Address **2901 14th St., N.W., Wash., D.C.**

2-27 19 48 Mary C. Patterson

(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Colorado** County.....City or town..... **Colorado Springs**

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... **27 February** 19 48 at 9:15AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
26 December 19 47 to **27 Feb.** 19 48and that I last saw h. er alive on **27 Feb.** 19 48

Immediate cause of death.....

Brachiectasis for Advanced Left Lung.

Due to.....

Due to.....

Other conditions..... **Multiple Adhesions Left Lung** Months 6-8
SHOCK - P.T.O. Opener 20 hrs

(Include pregnancy within 3 months of death)

Major findings or operations..... **Brachiectasis 8 multiple adhesions Left Lung** Date of op. **2-26-48**Autopsy results..... **Brachiectasis for Advanced Left Lung** PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

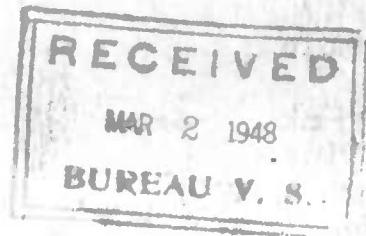
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... **R. N. Shelley** M. D. or other
R. N. SHELLEY, Cdr. MC USNAddress..... **USNH Bethesda, Md.** Date signed **2-27-48**



~~PLEASE WRITE PLAINLY, WITH UNFADING INK.~~ Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01782

Reg. Dist. No. 214

CERTIFICATE OF DEATH

95c

1. PLACE OF DEATH:
 County.....Montgomery
 City or town.....Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Street address where death occurred:
 607 McNeill Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland County.....Montgomery
 City or town.....Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....607 McNeill Rd.
 (If rural, give LOCATION)

3. (a) FULL NAME
 MRS. MARGARET ARNETT

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
female	white	widowed		
6. (b) Name of husband XXX James M.				
6. (c) If alive, give age years				
7. Birth date of deceased (mo., day, yr.) July 18th. 1872				
8. AGE:	Years	Months	Days	If less than one day
	75	7	9	hrs. min.
9. Birthplace Kentucky <small>(Town, county, and state)</small>				
10. Usual occupation Retired				
11. Industry or business				
12. Name Charles Patrick				
13. Birthplace Kentucky				
14. Maiden name (Elizabeth) Margaret Patrick				
15. Birthplace Kentucky				
16. Informant Mrs. Layman VanW Knight				
Address 607 McNeill Rd. Silver Spring				
17. Removal & Burial Date thereof 2-28-1948 <small>(Burial, cremation, or removal. Which?)</small>				
Cemetery XXX Lee City				
Location Wolfe Co. Kentucky				
18. Funeral director Charles E. Murphy, Jr.				
Address Silver Spring, Md.				
19. Date rec'd by registrar Feb 27 1948 Josephine Schreyer <small>(Date rec'd by registrar)</small>				

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1948 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10 1948, to Feb. 27, 1948, and that I last saw her alive on Feb. 27, 1948.

Immediate cause of death Circum cardia outlet 10 min DURATION

Due to generally ill 1 year

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

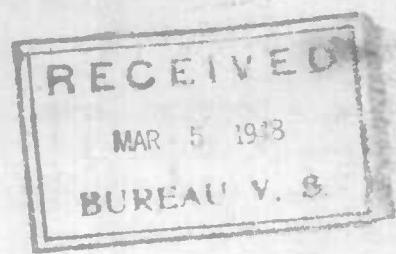
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.B. Wadley M.D. or other

Address 943 Bonfant St. Date signed 2/28/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

200 a

2184

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
 County Montgomery Co.
 City or town North Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 Years
 Hospital, institution, or street address where death occurred:
 Conn. Ave. Near Jones Bridge Road
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
 Street No. 9504 Jones Mill Road,
If rural, give LOCATION
 2.(a) If veteran, name war None

3. (a) FULL NAME

Wallace B. Arthur

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6. (b) Name of husband or wife Mary Ellen Arthur

7. Birth date of deceased (mo. day, yr.) August 22, 1874

8. AGE:	Years	Month	Day	If less than one day
	73	73	6	4
				hrs. min.

9. Birthplace Iredell Co., North Carolina
(Town, county, and state)

10. Usual occupation Handymen

11. Industry or business

MOTHER FATHER	12. Name	Amos Arthur
	13. Birthplace	North Carolina

	14. Maiden name	Mary Pyller
	15. Birthplace	North Carolina

16. Informant	Mrs. Wilma Stoupe
	Dallas, North Carolina

17. Cremation	Date thereof April 22, 1948
	(Burial, cremation, or removal. Which?)
	Cemetery or crematory Cedar Hill Crematory

Location	Prince George Co, Washington, D.C.
18. Funeral director	W. Kubra Humphrey
Address	Bethesda, Maryland

19. (Date rec'd by registrar)	4/22/48	Mr. E. Gold	Registrar
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3. (b) Social Security Number
None

MEDICAL CERTIFICATION

About Feb. 26, 1948

20. DATE OF DEATH Unknown 19 al M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
and that I last saw him alive on

Immediate cause of death

Unknown -

Due to Natural causes

Body found in bushes along
side of Jones Bridge Rd
Cherry Lane.

Other conditions

Body badly decomposed

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

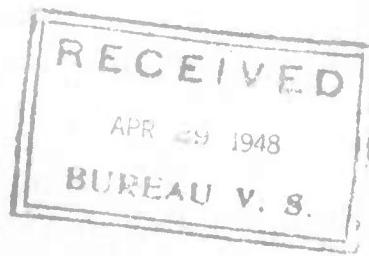
Name of Injury Injured at work?

Meane of Injury

Signature Frank J. Bisschot M.D.

23. SIGNATURE Frank J. Bisschot M.D. M. D. or other

Address Gaithersburg Md Date signed 4/24/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01783
214

1. PLACE OF DEATH:
 County Montgomery
 City or town Silver Spring
(If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution:
10316 Old Bladensburg Rd.
 Stay in hospital or inst. (yrs., or mos., or days)
 Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State Maryland County Montg.
 City or town Silver Spring
(If outside city or town limits, write RURAL NEAR and give town)
 Street No. 10316 Old Bladensburg Rd.
(If rural give LOCATION)
 2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME
George Howard Bean

4. Sex <u>male</u>	5. Color or race <u>white</u>	6. (a) Single, married, widowed, or divorced <u>widowed</u>	
6(b) Name of husband or wife <u>Mary Jane</u>			
6(c) If alive, give age _____ years			
7. Birth date of deceased (mo. day, yr.) <u>Mar. 6th. 1864</u>			
8. AGE: Years <u>83</u>	Months <u>11</u>	Days <u>21</u>	It less than one day
hrs. _____ min. _____			
9. Birthplace <u>Maryland</u> <small>(Town, county, and state)</small>			
10. Usual occupation <u>Retired Farmer</u>			
11. Industry or business			
MOTHER FATHER	12. Name <u>John Bean</u>		
	13. Birthplace <u>Maryland</u>		
	14. Maiden name <u>Unknown</u>		
	15. Birthplace		
16. Informant <u>Mr. Harry Bean (son)</u>			
Address <u>10316 Old Bladensburg Rd.</u>			
17. Burial		Date thereof <u>3/1/1948</u>	
(Burial, cremation, or removal. Which?)		(month) (day) (year)	
Cemetery or crematory <u>Colesville Church</u>			
Location <u>Colesville, Montg. Co., Md.</u>			
18. Funeral director <u>Warren C. Lumpkin</u>			
Address <u>Silver Spring, Md.</u>			
19. <u>Feb 29 1948</u>		Josephine Schaeffer	
(Date rec'd by registrar)		Registrar	

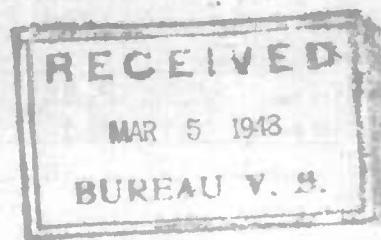
3. (b) Social Security Number
none

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 Feb. 1948

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Cent 1946 to 27 Feb 1948, and that I last saw him alive on 27 Feb 1948.

Immediate cause of death <u>Cerebral embolus</u>	DURATION <u>5 days</u>
Due to <u>cardiac fibrillation</u>	<u>6-8 yrs</u>
Due to	
Other conditions <u>Cardiac decompensation</u>	
(Include pregnancy within 8 months of death)	
Major findings:	
Dt operations	
Dt autopsy	
PHYSICIAN	
Please underline the cause to which death should be charged statistically.	
22. VIOLENCE: If death was due to external causes, fill in the following:	
Accident, suicide, or homicide	Date of
Where did injury occur?	(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)	
Means of injury	Injured at work?
23. SIGNATURE <u>William D. Auf M.D.</u>	
M. D. or other	
Address <u>Silver Spring, Md.</u> Date signed <u>2-7-1948</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01784

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH:

County.....

Montgomery

Rural

City or town.....

Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Hollywood Park

How long in hospital or institution?

3. (a) FULL NAME

Waldo E. Bennett

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male white married

6.(b) Name of husband or wife

Ottie Bennett

7. Birth date of deceased (mo., day, yr.)

Apr 20 1869

64 years

8. AGE:

Years	Months	Days	If less than one day
78	10	6	hrs. min.

9. Birthplace.....

(Town, county, and state)

W. Va

10. Usual occupation.....

Farmer

11. Industry or business

MOTHER FATHER

12. Name.....

Oliver Bennett

13. Birthplace.....

W. Va

14. Maiden name.....

Mary Haddot

15. Birthplace.....

W. Va

16. Informant.....

Ottie Bennett

Address.....

Silver Spring Md

17. BURIAL

(Burial, cremation, or removal? Which?)

Date thereof.....

FEB - 28 - 1948

(month) (day) (year)

Cemetery or crematory.....

FORT LINCOLN.

Location.....

PRINCE GEORGES Co - MARYLAND

18. Funeral director.....

Warren E. Humphrey Jr.

Address.....

SILVER SPRING - MD

19. Date rec'd by registrar.....

Feb 27

19

4.8 Josephine Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Montgomery

City or town.....

Tiller

Spring

(If outside city or town limits, write RURAL and give nearest town)

(If rural, give LOCATION)

Street No.....

Hollywood Park

2.(a) If veteran, name w/.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH.....

Feb

26

1948 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h.....alive on

Immediate cause of death.....

Coronary occlusion

Due to.....

Due to.....

Other conditions.....

Hypertension

DURATION

and

deadly

2 yrs

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

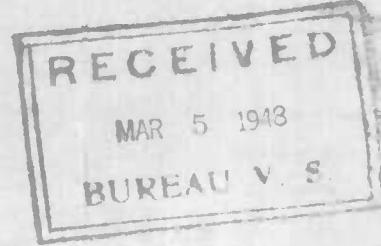
Frank J. Borchart M.D.

Physician and Examiner M.D. or other

Address.....

Hollywood Park

Date signed 2-26-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, write the causes of death clearly and legibly. It is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01785

CERTIFICATE OF DEATH

Reg. Dist. No. 514

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

915 Philadelphia Avenue

How long in hospital or institution?

3. (a) FULL NAME

SUSIE E. BERRY

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

femalewhitewidowed6.(b) Name of husband xxx George Berry

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

August 11, 1857

8. AGE:

Years
90Months
6Days
1

If less than one day

hrs.

min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation Retired Housewife

11. Industry or business

12. Name Unknown13. Birthplace Virginia14. Maiden name Unknown15. Birthplace Unknown16. Informant William H. Berry, sonAddress 915 Phila. Ave., Silver Spring, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 14, 1948
(month day year)Cemetery xxx Cedar Hill CemeteryLocation Suitland, Pr. Geo. Co., Md.18. Funeral director Elmer E. HumphreyAddress 8434 Ga. Ave., Silver Spring, Md.19. Feb. 13, 1948 J. L. Schaeffer
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 915 Philadelphia Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12 1948 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 13 1947 to Feb. 12 1948and that I last saw her alive on Feb. 11 1948Immediate cause of death Cerebral Thrombosis DURATIONyes -Due to Generalized arteriosclerosis DURATIONyes -Due to Senility DURATIONyes -

Other conditions (Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Garry J. Kearns M.D. M. D. or otherAddress 608 Forest Glen Rd. Date signed Feb. 12 1948



~~PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, line correctly, and legibly.~~
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

01786

CERTIFICATE OF DEATH

Reg. Dist. No. 716

1. PLACE OF DEATH:

County MontgomeryCity or town Cherry Chase
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

MRS. MARTHA Elizabeth

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MDCounty MontgomeryCity or town Cherry Chase
(If outside city or town limits, write RURAL and give nearest town)Street No. 4611 DeRussey Parkway
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

BOLT

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FEMALEwhiteWidowed

6.(b) Name of husband or wife

Mantraville T. Bolt

6.(c) If alive, give age.....years

7. Birth date of deceased (mo. day, yr.)

October 17 1860

8. AGE:

87326If less than one dayhrs.min.

9. Birthplace

Smith County Virginia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

George KeyleyVirginia13. BirthplaceJANE MUSSERVirginia14. Maiden nameMR. WALTER M. MAYAddress 4611 DeRussey Pkwy.

18. Informant

17. Burial

(Burial, cremation, or removal, Which?)

Date thereof Feb. 16, 1948
(month) (day) (year)Cemetery or crematory Ft. Lincoln CemeteryLocation Washington, D.C.

18. Funeral director

S. A. Hines Co.Address 2901-14th Street N.W. Washington, D.C.19. 2/13/48 1948 JM E Jones

(Date rec'd by Registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 13 1948 at 3:20 PM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

September 1947 to Feb. 13 1948and that I last saw her alive on Feb. 12 1948

Immediate cause of death

PNEUMONIA, Bronchial

DURATION

ONE DAYDue to ARTERIOSCLEROTIC, CARDIOVASCULAR DISEASE

YEARS

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

D. Witt E. DeLawter M.D.

M. D. or other

Address 7345, Wisconsin Ave

Bethesda, Md.

Date signed 2-13-48

RECEIVED

FEB 21 1948

BUREAU V. S.

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

01787

Film No. G 114 APR 6 1948

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

CHEVY CHASE, MARYLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

MRS MARY LOCKWOOD BROWNE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F W MARRIED.

6. (b) Name of husband or wife.....

GEN FREDERICK W. BROWNE

8. (c) If alive, give age..... years

7. Birth date of
deceased (mo., day, yr.)

OCT 16, 1877

8. AGE:

Years

Months

Days

If less than one day

70 3 18 hrs. min.

9. Birthplace.....

AIKEN So. Carolina

(Town, county, and state)

10. Usual occupation.....

HOUSEWIFE

11. Industry or business

12. Name.....

PAUL LOCKWOOD

MOTHER FATHER

13. Birthplace.....

So. CAROLINA

14. Maiden name.....

JEAN BOOG

15. Birthplace.....

So. CAROLINA

16. Informant.....

GEN FREDERICK BROWNE

Address

4608 Langdum Lane - Ch. H. m.

17. Burial

Date thereof.....

(month) (day) (year)

(Burial, cremation, or removal) Which?

Feb 11, 1948

Cemetery or crematory

Cold Spring Park Cemetery

Location.....

75 Mtn. Virginia

18. Funeral director.....

PS Gauley & Sons

Address

100 Linn Lane NW WASH. D.C.

19. (Date rec'd by registrar)

3/10

19. 48

PM E Jobs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

MARYLAND

County.....

Montgomery

City or town.....

CHEVY CHASE

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

4608 Langdum Lane

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Feb 9 1948 at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 1945 to *Feb 9 1948*

and that I last saw him alive on *Feb 8 1948*

Immediate cause of death.....

Pneumonia (terminal)

DURATION

3 days

Due to..... *General arteria sclerosis* *+ hypertension* *10 yrs*

Duo to..... *Myocardial Infarction* *2 yrs*

Other conditions..... *Left sided Aemphysema* *1/2 yrs*

(Include pregnancy within 8 months of death)

Major findings or operations.....

..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE.

Gilbert B. Rude M.D.

M. D. or other

Address..... *3900 Military Rd N.W.*

Date signed *2/9/48*

RECEIVED

FEB 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01788

CERTIFICATE OF DEATH

127as
Reg. Dist. No. 213

1. PLACE OF DEATH:

County

City or town Lincoln Park, Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

6. (b) Name of husband or wife

Elijah Campbell

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

March 10, 1878

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Mt. Zion, Md.

(town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

Charles Campbell

MOTHER FATHER

12. Name

Mt. Zion, Md.

13. Birthplace

Mt. Zion, Md.

14. Maiden name

Mattie Joppy

15. Birthplace

Md.

16. Informant

Elijah Campbell (wife)

Address

Lincoln Park, Rockville

17. Burial

Burial

Date thereof Feb 11, 1948

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Lincoln Park

Location

Rockville, Md.

18. Funeral director

Robert L. Snodder

Address

Rockville, Md.

19. Date rec'd by registrar

1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

only

City or town

Lincoln Park

Rockville, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If Veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 8 1948 at 50 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 8 1948 to Feb 8 1948

and that I last saw him alive on Feb 8 1948

Immediate cause of death

Respiratory

DURATION

Due to

acute nephritis

Due to

—

Other conditions

cerebral

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

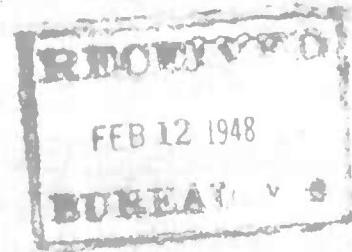
injured at work?

23. SIGNATURE

R. Thompson
Smithsonian Institution
Date signed Feb 10/48

Address

M. D. or other



PLEASE WRITE PLAINLY, IN BLACK UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 216

01789

CERTIFICATE OF DEATH

46d

1. PLACE OF DEATH:
 County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 days
 Hospital, institution, or street address where death occurred:
 US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 35 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State D.C. County Washington
 City or town (If outside city or town limits, write RURAL and give nearest town)
 Street No. 14621 N. Capital St., N.W.
 (If rural, give LOCATION)
 PNTI
 2.(a) If veteran, name war. ✓

3. (a) FULL NAME

CARR, John William

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife Anna M. Carr

7. Birth date of deceased (mo., day, yr.) November 20, 1888

8. AGE: Years Months Days If less than one day
59 2 11 hrs. min.

9. Birthplace Wash., D.C.
(Town, county, and state)

10. Usual occupation unknown

11. Industry or business

MOTHER FATHER
 12. Name CARR, Joseph dec.
 13. Birthplace Va.

14. Maiden name MURPHY, Mary dec.
 15. Birthplace Ireland

16. Informant Wife: Mrs. Anna M. Carr

Address 4621 N. Capital St., N.W., Wash., D.C.

17. burial Date thereof 2-5-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National
Location Arlington, Va.

18. Funeral director S. H. HINES W.A.S.
Address 2901 14th St., N.W., Wash., D.C.

19. 2-1 19 48 Mary C. Patterson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 19 48 at 11:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29 19 47 to Feb. 1 19 48 and that I last saw h. im. alive on 2-1 19 48

Immediate cause of death

Bronchopneumonia

DURATION

4 da

Due to

Due to

Other conditions Adenocarcinoma of the rectum & metastasis 2 1/2 yrs
(Include pregnancy within 3 months of death)

Major findings of operation Adenocarcinoma
of rectum confirmed alone Date of op. March '46
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

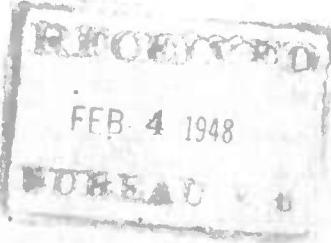
Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Dr. R. B. H. Webster, Lt. MG MCNUSN
R. B. H. Webster, Lt. MG MCNUSN

23. SIGNATURE. M. D. or other

Address USNH Bethesda, Md. Date signed 2-1-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01790

CERTIFICATE OF DEATH

Reg. Dist. No. 213

THE
MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The
correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				
County <u>MONTGOMERY</u>				
City or town <u>ROCKVILLE</u> (If outside city or town limits, write RURAL NEAR and give town)				
Street address, hospital, or institution: <u>CHESTNUT LODGE SANITARIUM</u>				
Stay in hospital or Inst. (yrs., or mos., or days) <u>1 month 6 days</u>				
Stay in this community (yrs., or mos., or days) <u>1 month 6 days</u>				
3. (a) FULL NAME <u>CASSEY, MILLER AIKEN</u>				
4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced		
<u>MALE</u>	<u>WHITE</u>	<u>WIDOWED</u>		
B (b) Name of husband or wife <u>MABEL CASSEY</u>				
6(c) If alive, give age _____ years				
7. Birth date of deceased (mo., day, yr.) <u>Oct. 8, 1887</u>				
8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>4</u>	<u>2</u>	hrs. _____ min.
9. Birthplace <u>BOSTON, MASS.</u> (Town, county, and state)				
10. Usual occupation <u>CIVIL SERVICE</u>				
11. Industry or business <u>DEPT. OF COMMERCE</u>				
12. Name <u>JOHN I. CASSEY</u>				
13. Birthplace <u>OHIO</u>				
14. Maiden name <u>VESTA HARVEY</u>				
15. Birthplace <u>OHIO</u>				
16. Informant <u>VESTA H. CASSEY, daughter</u>				
Address <u>1308 Anson St. Silver Spring</u>				
17. Burial Date thereof <u>Feb. 12, 1948</u> (Burial, cremation, or removal. Which?) (month) (day) (year)				
Cemetery or crematory <u>Monocacy</u>				
Location <u>Beallsville, Md.</u>				
18. Funeral director <u>Warren E. Humphrey</u>				
Address <u>Silver Spring, Md.</u>				
19. <u>2/12</u> 1948 (Date rec'd by registrar) <u>E.P. Thompson</u> (Per Secretary)				

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State <u>MARYLAND</u>	County <u>MONTGOMERY</u>
City or town <u>SILVER SPRING</u>	Ward No. _____
Street No. <u>1308 Anson Street</u>	(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 FEBRUARY 1948, at 4:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4 JANUARY 1948, to 10 FEBRUARY 1948, and that I last saw him alive on 10 FEBRUARY 1948.

Immediate cause of death BRONCHIOPNEUMONIA,
BILATERAL, RECURRENT DURATION 1 mon.

Due to CEREBRAL ACCIDENT, RIGHT, TYPE
undetermined 1 WK

Due to CEREBRAL ARTERIOSCLEROSIS 2

Other conditions SENIILE DEMENTIA 2 mos.

(Include pregnancy within 8 months of death)

Major findings:
Of operations
Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

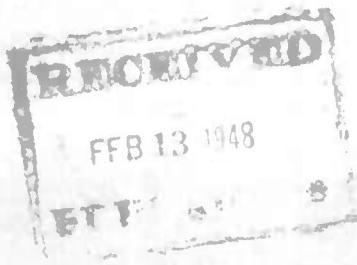
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work?

23. SIGNATURE Robert J. Harvey MD M. D. or otherAddress Chestnut Lodge Date signed 10 Feb

48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01791
223

Reg. Dist. No.

1. PLACE OF DEATH:

County

Montgomery

City or town

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Seven weeks

Hospital, institution, or street address where death occurred:

Washington San. & Hospital

How long in hospital or institution?

seven weeks

3. (a) FULL NAME

Helene Jeanne Cockeyer

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

married.

6.(b) Name of husband or wife

Charles Albert Cockeyer

7. Birth date of deceased (mo., day, yr.)

May 24, 1889

8.(c) If alive, give age 57 years

8. AGE:

58

Years

Months

Days

It less than one day

hrs.

min.

9. Birthplace

Neuchatel, Switzerland

(Town, county, and state)

10. Usual occupation

Business woman

11. Industry or business

Restaurant (now retired)

12. Name

Fritz Widmer

13. Birthplace

Neuchatel, Switzerland

14. Maiden name

unknown

15. Birthplace

16. Informant

Mr. Charles Cockeyer

Address 1404 Park Rd. N.W.

17. (Cremation

(Burial, cremation, or removal. Which?)

Date thereof Feb. 7, 1948

(month) (day) (year)

Cemetery or crematory

Fort Lincoln Cemetery

Location

Washington D.C.

18. Funeral director

S.H. Hines Co.

Address

2901 14th St. N.W.

19. Date rec'd by registrar

Feb 5 1948

(Date rec'd by registrar)

20. Signature

R. A. Dunn, M.D.

Signature

of Deceased

21. Address

Washington San. & Hospital

22. Date signed

2/5/48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C.

County

Washington (N.W.)

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1404 Park Rd. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 5, 1948 19 at 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dec. 4, 1947 to Feb. 5, 1948

and that I last saw her alive on Feb. 5, 1948 19.

Immediate cause of death

Periperal circulatory failure

Due to heart failure

Due to carcinoma of rectum

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Carcinoma of rectum

Intestine ca. of liver

Date of op. Dec. 18, 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. A. Dunn, M.D.

M. D. or other

Address Washington San. & Hospital

Date signed 2/5/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01792
53+

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County

City or town

Chevy Chase
Montgomery

(If outside city or town limits, write RURAL and give nearest town)

Now long in above place of death?

3 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Elizabeth Mayo Clay

3. (b) Social Security Number

nones

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

B. (b) Name of husband or wife

Roderick Odie Clay

B. (c) If alive, give age 30 years

7. Birth date of deceased (mo., day, yr.)

Mar. 31 - 1916

8. AGE:

Years

Months

Days

If less than one day

31

10

6

hrs.

min.

9. Birthplace

Augusta Georgia

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

12. Name

Rudolph Parsons Mayo

13. Birthplace

Ia

14. Maiden name

Willie Bell

15. Birthplace

I. C.

16. Informant

Roderick O Clay

Address

100 E Underwood St.

17. Cemetery or crematory

West View Cemetery

Date thereof Feb. 10 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Atlanta

Location

Augusta Georgia

18. Funeral director

George W. Neal Co. Inc.

Address

2900 M St N.W. Washington D.C.

19. (Date recd by registrar)

2/7 1948

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

Montgomery

Chevy Chase

100 E Underwood St

(If rural, give LOCATION)

2.(a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/6 1948 at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 2 1947 to Feb. 6 1948

end that I last saw h. rr. alive on Feb. 6 1948

Immediate cause of death

Secondary anemia

Due to Non pigment malignant

melanoma involving left eyeball

Due to temporal region, left eye +

rt lung

690

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

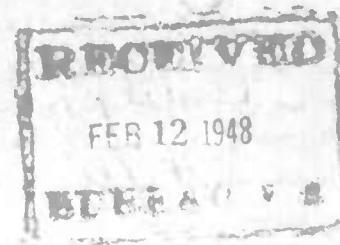
Means of injury Injured at work?

23. SIGNATURE G.W. Culver M.D.

M. D. or other

Address 3781 Chevy Chase

Date signed 2/7/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

137a

CERTIFICATE OF DEATH

Reg. Dist. No. 223

01793

1. PLACE OF DEATH:

County

Montgomery

City or town

Takoma Park Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

21 years

Hospital, institution, or street address where death occurred:

Washington Sanitarium, Md., Takoma Park, Md.

How long in hospital or institution?

20 days

3. (a) FULL NAME

Arthur Pardon Cook

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

Widower

6. (b) Name of husband or wife

Ella A. Cook

7. Birth date of deceased (mo., day, yr.)

December 13, 1860

6. (c) If alive, give age — years

8. AGE:

Years

Months

Days

If less than one day

87

2

0

hrs.

min.

9. Birthplace

Geauga County, Chardon, Ohio

(Town, county, and state)

10. Usual occupation

County Commissioner

11. Industry or business

Same

12. Name

Alpheus Cook

13. Birthplace

Vermont

14. Maiden name

Laura Sanderson

15. Birthplace

Ohio

16. Informant

George A. Cook (son)

Address

22 Denwood Ave. Takoma Park Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 16, 1948
(month) (day) (year)

Cemetery or crematory

Geo. Wash. Memorial Cem.

Location

Ridge Rd. Hyattsville, Md.

18. Funeral director

Arthur Cook

Address

254 Carroll St. Takoma Park, Md.

19. Date rec'd by registrar

Feb. 14, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Montgomery

City or town

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 22 Denwood Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

2-13

1948

21 3 40 M

21. I CERTIFY that death occurred on the date above stated that I last knew deceased from

Jan. 23 1948 to Feb. 13 1948
and that I last saw h. alive on Feb. 13 1948

Immediate cause of death

Congestive heart failure

Due to Coronary sclerosis heart disease

Due to

Other condition Benign prostatic hypertrophy

(Include pregnancy within 3 months of death)

Major findings or operations Benign prostatic hypertrophy

Date of op. Feb. 6, 1948

Autopsy results (as above)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

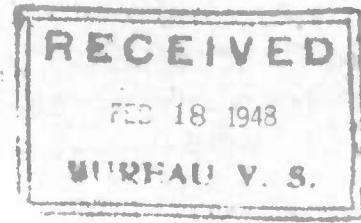
Means of injury Injured at work?

23. SIGNATURE

R. A. Dunn, M.D.

M. D. or other

Washington Jan. 7 1948 Date signed Feb. 13, 1948



PLEASE WRITE PLAINLY, WITH INK FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 212

01794
212

1. PLACE OF DEATH:

County

City or town

Montgomery
Rockville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

LIFE -

How long in hospital or institution? None

3. (a) FULL NAME

Ada B. Cranford

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female white Widowed

6.(b) Name of husband or wife

Joseph H. Cranford

7. Birth date of deceased (mo., day, yr.)

September 2, 1871

6.(c) If alive, give age .. years

8. AGE:

Years Months Days If less than one day

76

76

5

24

.....

hrs.

.....

min.

9. Birthplace

Washington, D. C.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

None

MOTHER FATHER

12. Name

Joseph Twissowski

13. Birthplace

Poland

14. Maiden name

Ada Bassett

15. Birthplace

Washington, D. C.

16. Informant

Henry S. Cranford

Address

Rockville, Maryland

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof March 1, 1948

(month) (day) (year)

Cemetery or crematory

Rock Creek Cemetery

Location

Washington, D. C.

18. Funeral director

Wm. L. Thompson

Address

Bethesda, Maryland

19. Date rec'd by registrar

3-1

1948

E. P. Thompson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Montgomery

City or town

Rockville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Fall's Road at Bell's Mill

(If rural, give LOCATION)

2.(a) If veteran, name war

None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

2/26

1948 2/11SP

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/20

1948

2/26 1948

and that I last saw h. e. alive on

2/25

1948

1948

Immediate cause of death

Orenda

DURATION

24W.

Due to Hypertension and heart disease

5 years

Due to Hypertension

10 years

Other conditions Congestive heart failure

2 years

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE

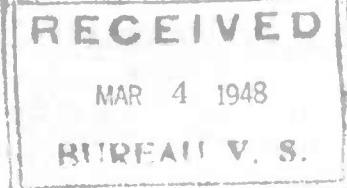
W. W. Welch 20

M. D. or other

Address

Rockville

Date signed 3/26/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

017953-

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... MontgomeryCity or town... Takoma Park, Maryland

Since 1942 (If outside city or town limits, write RURAL and give nearest town)

Lived in Montgomery 28 days

How long in above place of death...

Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital

How long in hospital or institution? 28 days

3. (a) FULL NAME

Mrs Mae Andre Cummins

4. Sex

5. Color or race

6.(c) Single, married, widowed, or divorced

FewhiteWidowed6.(b) Name of husband or wife deceased

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

73

9

6

hrs. min.

9. Birthplace Franklin Furnace, OHIO

(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

12. Name Claudius Andre13. Birthplace Unknown14. Maiden name Mary Jane Lamb15. Birthplace Unknown16. Informant Mrs Corwin C. CumminsAddress 1521 W. 10th St. Anderson Indiana17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 10, 1948
(month) (day) (year)Cemetery or crematory Brownwood CemeteryLocation Hinsdale Illinois18. Funeral director J. Arthur WaltersAddress 254 Carroll St. NW. Takoma Park, DC19. Feb. 8 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland

County

MontgomeryCity or town... Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 602 Garland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7 1948 at 8:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

1945 to Feb 7 1948and that I last saw her alive on Feb 7 1948

Immediate cause of death

Congestive Cardiac Failure DURATION terminalDue to Hypertension Years

Due to

Cerebral Hemorrhage 2 weeks

Other conditions (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Robert A. Hare MDM. D. or other Dakota Park, MD Date signed 2/7/48

Address

Registrar



✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46f
01796
Reg. Dist. No. 296

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County... MontgomeryCity or town... Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ... Since 1-21-'48Hospital, Institution, or street address where death occurred: Suburban Hosp8600 Old Georgetown Rd, Bethesda - Md.How long in hospital or institution? ... since 1-21-'48

3. (a) FULL NAME

Mr Armstead P. Curtis

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m

w

6. (b) Name of husband or wife

Pauline Curtis

7. Birth date of deceased (mo., day, yr.)

March 23, 19088. (c) If alive, give age 35 years

8. AGE:

Years

Months

Days

If less than one day

39

10

12

hrs. min.

9. Birthplace

Seneca, Md.

(Town, county, and state)

10. Usual occupation

chauffeur

11. Industry or business

Naval Ordnance

MOTHER FATHER

12. Name John W. Curtis13. Birthplace Fredericksburg, Virginia14. Maiden name Carrie Maxley15. Birthplace Fredericksburg, Virginia

16. Informant

Mrs Armstead CurtisAddress Germantown, Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 2/8/48
(month) (day) (year)

Cemetery or crematory

Presbyterian

Location

Darnes Tow, Md

18. Funeral director

William B. Hilton

Address

Barnesville, Md18. Feb 7, 1948

(Date rec'd by Registrar)

Wm E. Miller

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State R.I.R #2 Md., County MontgomeryCity or town Germantown, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. R.R. #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

214-03-6285

32

MEDICAL CERTIFICATION

20. DATE OF DEATH

2-5

1948 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec - 1947 to Feb - 5 - 1948
and that I last saw him alive on Feb - 5 - 1948

Immediate cause of death

Pneumonia of liver (Paramonyx)

DURATION

2 mo

Due to

Due to

Pulmonary Thrombosis 48 hrs
11 days aging living 48 hrs.
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

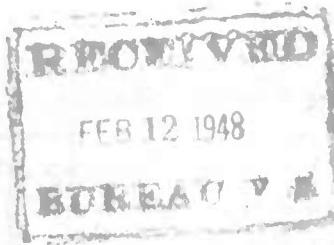
Injured at work?

23. SIGNATURE

Kathleen C. Miller MD

M. D. or other

Address Anthensburg, Md Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0179-216

1. PLACE OF DEATH: MONT.
 County.....
 City or town... CHEVY CHASE
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME
 DR NELSON H. DARTON

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced

6.(b) Name of wife ALICE DARTON

7. Birth date of deceased (mo., day, yr.) DEC. 17, 1865 8.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
 82 2 11 hrs. min.

9. Birthplace BROOKLYN, NEW YORK
 (Town, county, and state)

10. Usual occupation GEOLOGIST - U.S. GOVERNMENT

11. Industry or business

FATHER 12. Name William Darton

MOTHER 13. Birthplace Boston, Mass.

14. Maiden name Caroline Shayer

15. Birthplace New York, N.Y.

16. Informant Alice H. Darton

Address 6969-Brookville Rd

BURIAL 17. Date thereof MARCH 1, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory MOUNT OLIVET

Location WASHINGTON, D.C.

18. Funeral director Jas. Lawrence Jones

Address 706 Pa. Ave. N.W. Wash. D.C.

19. 2/29/48 Wm E. Jones
 (Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State MARYLAND County MONT.
 City or town CHEVY CHASE
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 69 69 BROOKVILLE ROAD
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 28, 1948 19:12:30 a.m.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 March 15, 1948, to Feb. 28, 1948,
 and that I last saw h. in alive on Feb. 26, 1948.

Immediate cause of death chronic myocarditis DURATION 2 yrs.

Due to Generalized arterio-sclerotic disease 10 yrs.

Due to

Other conditions Marfan's syndrome, fibrosis of old adhesions

(Include pregnancy, etc.)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

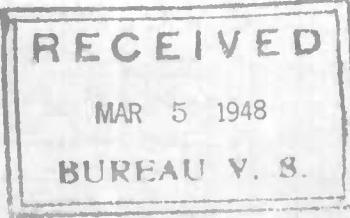
Where did injury occur? (City or town) (County) (State)

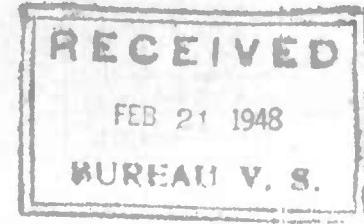
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George Sawyer M.D. or other

Address 629 Col. Review 2/28/48 Date signed





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157d

12873

01799

216

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution?

6 hours

3. (a) FULL NAME

Russell T. Edwards

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white widower

B. (b) Name of husband or wife

Venita Parker Edwards

dec.

7. Birth date of deceased (mo., day, yr.)

Aug. 26, 1878-

8. AGE:

Years
69Months
58Days
8It less than one day
hrs. min.

9. Birthplace.....

(Town, County, and state)

Brigdon Ontario, Canada

10. Usual occupation.....

Retired

11. Industry or business

12. Name..... Wm G. Edwards

13. Birthplace..... Wales

14. Maiden name..... Martha Bridge

15. Birthplace..... Wales

16. Informant..... Burke Edwards (son)

Address..... same

17. Burial..... Date thereof F.e.b. 6, 1948
(Burial, cremation, or removal, which?)

(month) (day) (year)

Cemetery or crematory..... National Memorial Park

Location..... Arlington, Virginia

18. Funeral director..... Wm. Lander Pennington

Address..... Bethesda, Maryland

19. Fed.: 6 1948
(Date rec'd by registrar)Nm 6 Jones
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)Street No..... 302 bunn Drive
(If rural, give LOCATION)

2.(a) If veteran, name war..... None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 3,

1948 at 8:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 1947 to Feb. 3, 1948

and that I last saw him alive on Feb. 3, 1948.

Immediate cause of death..... Parenchymal confluent
leukemia both lungs - Terminal -

Duration

3 days.

Parenchymal leukemic

Due to..... Parenchymal Right upper
Central lobe of terminal - Congenital -

Due to.....

Internal Hydrocephalus Chronic -
Bilateral

Other conditions

Prostate Hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... no above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... John B. Ball M.D.

M. D. or other

Address..... 7936 Georgetown Rd Bethesda Date signed 4/24/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01890

159

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

How long in above place of death?

Birth -

Hospital, institution, or street address where death occurred:

Suburban Hospital - Old Georgetown Rd.

How long in hospital or institution?

Birth

3. (a) FULL NAME

John Samuel Flemings

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

—

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

February 28-1948

8. AGE:

Years

Months

Days

If less than one day

1 4 hrs. 1 min.

9. Birthplace

Suburban Hospital Bethesda Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name Samuel Franklin Flemings

13. Birthplace

Harpers Ferry, West Virginia

14. Maiden name

Lillian Mary Nelson

15. Birthplace

New York City, New York

16. Informant

Samuel Franklin Flemings

Address

625 Monroe St. N.W. Wash. D.C.

17. Cremation

Date thereof March 1 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Suburban Hospital

Location

Bethesda Md

A.B. Salomone, M.D.

18. Funeral director

Berkshire 14. Md

Address

3161 1948

2pm E. Jones

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No.

625 Monroe St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 29 1948 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Feb 28 1948 to

and that I last saw him alive on Feb 28 1948

Immediate cause of death

Subarachnoid hemorrhage

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

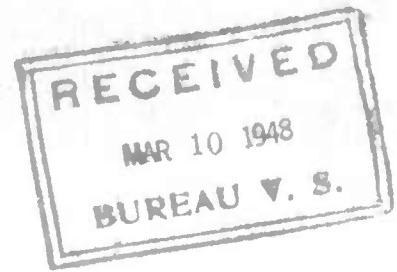
Injured at work?

23. SIGNATURE

Address

So 16 Aug 1948 M. D. or other

Date signed 2/29/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

01801

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County... Montgomery
City or town... Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital, Inc.

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Germantown
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near... Dama. E.C.H.S.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alice Foreman

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Col. Married

6.(b) Name of husband or wife Westley Foreman

7. Birth date of deceased (mo., day, yr.) March 17, 1894 6. (c) If alive, give age years

8. AGE: Years Months Days if less than one day 53 10 27 hrs. min.

9. Birthplace Montgomery County, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

MOTHER FATHER 12. Name George Carroll

13. Birthplace Montgomery County, Md.

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Hospital record:

Address

17. Burial, cremation, or removal. Which? Cremated Date thereof Feb 17, 1948
(month) (day) (year)

Cemetery or crematory John W. Kelly

Location Rockville, Md.

18. Funeral director Rayon Barbers

Address Laytonsville, Md.

19. Feb. 17, 1948 Gertrude B. Lawler
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1948, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9 1948, to February 14 1948,

and that I last saw her alive on February 14, 1948.

Immediate cause of death

Unarmed

DURATION

10 days

Due to Chronic Inflammation

Due to Arthritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

JMB 1
Sandy Spring, Md.

M. D. or other

Date signed 2/15/48

RECEIVED
MAR 12 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

018012

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

4819 St. Elmo Avenue,

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4819 St. Elmo Avenue

(If rural, give LOCATION)

None

2.(u) If veteran, name war.....

3. (a) FULL NAME

Mathilda Elizabeth Fulks

3. (b) Social Security Number
None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

John S. Fulks

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.)

July 1, 1888

8. AGE:

59

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore, Maryland

(Town, county, and state)

10. Usual occupation

Housewife

None

11. Industry or business

Max Felka

MOTHER FATHER

South Africa

12. Name

Amelia Lang

13. Birthplace

Baltimore, Maryland

14. Maiden name

Joseph Schwartz

Address

1817 18th St. S. E.

17. Burial

Date thereof February 8, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Forest Oak Cemetery

Cemetery or crematory

Gaithersburg, Maryland

Location

Wm. Random Remond

18. Funeral director

Bethesda, Maryland

Address

Wm E Jones

19. 218

19

48

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1948 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5, 1948, to Feb. 6, 1948, and that I last saw her alive on February 6, 1948.

Immediate cause of death

Cerebral hemorrhage

DURATION

24 hours

Due to

Arterio-sclerosis - hypertension

Due to

Chronic nephritis - hypertension

DURATION

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

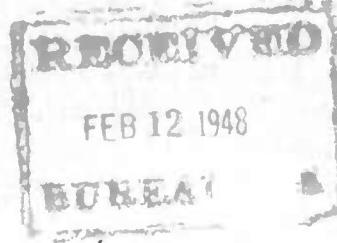
23. SIGNATURE

Address

M.D.

JAN 27 1948

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01803

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery

City or town... Potomac

(If outside city or town limits, write RURAL and give nearest town)

47 yrs.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

None

How long in hospital or institution? None

3. (a) FULL NAME

Mordecai Taylor Fussell

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Widowed

8. (b) Name of husband or wife... Isabelle Blair Fussell

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 11, 1852

8. AGE: Years Months Days If less than one day
95 95 8 15 hrs. min.9. Birthplace... Baltimore, Maryland
(Town, county, and state)

10. Usual occupation... Retired

11. Industry or business Fussells Ice Cream Co.

12. Name Jacob Fussell

13. Birthplace Hardford County, Maryland

14. Maiden name Amie Elizabeth Taylor

15. Birthplace Unknown

16. Informant Mr. Norris Fussell

Address Ashton, Maryland

17. Burial

Date thereof Feb. 28, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Green Mount Cemetery

Location Baltimore, Maryland

18. Funeral director Wm. L. Hansen

Address Bethesda, Maryland

19. Feb. 28 1948
(Date rec'd by registrar)Wm E. Jones
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Ashton (If outside city or town limits, write RURAL and give nearest town)

Street No....A.M.A.

(If rural, give LOCATION)

2.(a) If veteran, name war... None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH 26 Feb 1948 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 Feb 1948 to 26 Feb 1948 and that I last saw h. m. alive on 25 Feb 1948.

Immediate cause of death

Coronary Occlusion

DURATION

5 minutes

Due to Coronary Occlusion

5 yrs

Due to Arteriosclerosis

20 yrs

Other conditions Cellulitis bed sores

2 months

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Murphy M.D.
Rockville Md. M. D. or other
Address... Date signed 26 Feb 1948

RECEIVED

MAR 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct date is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01804

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County... Montgomery

City or town... Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 hrs 35 min

Hospital, institution, or street address where death occurred:

Washington San. Hosp.

How long in hospital or institution? 34 hrs 35 min

3. (a) FULL NAME

Gregory, Mr. George Wilson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M white widower

6. (b) Name of husband or wife... F.L.U. McINTYRE

Dec. 25, 1869

6. (c) If alive, give age... years
7. Birth date of deceased (mo., day, yr.)8. AGE: Years Months Days If less than one day
78 2 0 hrs. min.9. Birthplace... Bath N.Y.
(Town, county, and state)

10. Usual occupation... Retired

11. Industry or business

12. Name... Gregory, Charles

13. Birthplace... Bath, N.Y.

14. Maiden name... Hawkins, Jane

15. Birthplace... ?

16. Informant... MRS. E. E. McINTYRE

Address Box 492 - SILVER SPRING - MD.

17. BURIAL: Date thereof... Feb. 27 - 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... GRACE CHURCH CEMETERY

Location... WOODSIDE - MONTG. CO. MARYLAND

18. Funeral director... Warner & Murphy, Inc.

Address... SILVER SPRING - MD.

19. (Date rec'd by registrar)... Feb. 26, 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md.

County... Montgomery

City or town... BOX 492 Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No... BOX 492

(If rural, give LOCATION)

2.(a) If veteran, name war...

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH... 2- 25 1948 at 6:39 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 12, 1947 to 2-25 1948

and that I last saw him alive on 2-24 1948

Immediate cause of death

Bronchopneumonia

Due to Arteriosclerotic Heart Disease & Decompensation

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

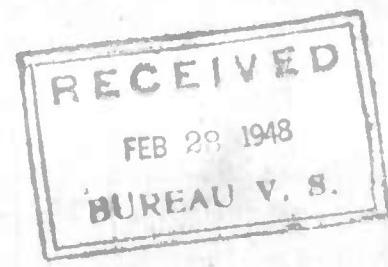
Injured at work?

23. SIGNATURE

John H. Slade, M.D. or other

Address... 1630 Carroll St NW Date signed 2-25-48

Registrar



PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1910
Reg. Dist. No. 213

018115

1. PLACE OF DEATH:

County Montgomery
 City or town Near Rockville and
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry Green

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male all widowed6.(b) Name of husband or wife Lilly Green

7. Birth date of deceased (mo., day, yr.)

June 22 1857

6.(c) If alive, give age years

8. AGE: Years

Months

Days

It less than one day

'918

hrs.

min.

9. Birthplace

(Town, county, and state)

Virginia(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

MOTHER FATHER

12. Name

Unknown

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Henry Green (son)

Address

Rockville, Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof March 2, 1948

(month) (day) (year)

Cemetery or crematory

Lincoln Park,

Location

Rockville, Maryland

18. Funeral director

R. L. Swanson

Address

Rockville, Maryland

19. 3 - 2

19 48

(Date rec'd by registrar)

S. P. Thompson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Montgomery
 City or town Near Rockville, Md.
(If outside city or town limits, write RURAL and give nearest town)
 Street No. Beantown
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 29 1948 at 9 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1948 1948 to Feb 29 1948and that I last saw him alive on Feb 29 1948Immediate cause of death Chronic Myocarditis DURATION

Due to

Due to

Other conditions Arteritis Behcet's
Chronic nephritis (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. E. Hawks M. D. or otherAddress Rockville, Md. Date signed 3/2/48

T

RECEIVED

MAR 4 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Reg. Dist. No. 223

CERTIFICATE OF DEATH

94a
018116
223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 1/2 hrs.

Hospital, institution, or street address where death occurred:

Washington San + HospitalHow long in hospital or institution? 1 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Prince Georges
 City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1013 Hopewell Avenue

(If rural, give LOCATION)

3. (a) FULL NAME

Mrs. Catherine Greulich

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FeCauc.Married

6.(b) Name of husband or wife

Joseph E. Greulich

7. Birth date of deceased (mo., day, yr.)

Sept 12, 1904

6.(c) If alive, give age.....years

8. AGE:

Years
43Months
4Days
27It less than one day
hrs. min.

9. Birthplace

Brooklyn, New York

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

George Mermaid

MOTHER FATHER

12. Name

George Mermaid

13. Birthplace

New York

14. Maiden name

Ida

15. Birthplace

New York

16. Informant

Mr. Joseph E. Greulich

Address

1013 Hopewell Ave. Tak. Pk. Md.

17. Burial (Burial, cremation, or removal. Which?)

CremationDate thereof Feb. 14, 1948

(Monthly (day) (year))

Cemetery or crematory

George Washington Mem.

Location

J Arthur Walters

18. Funeral director

Arthur Walters

Address

254 Carroll St. NW. Takoma Park, DC

19. (Date rec'd by registrar)

Feb 10 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9, 1948 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dyn Med Examin Corp. 19.and that I last saw h.....alive on 19.

Immediate cause of death

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank J. Broshart M.D.Dyn Med. Exam M. D. or otherAddress Hopewell Ave. Takoma Park, MD Date signed 2-9-48



PLEASE WRITE PLAINLY WITH UNEADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01807

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 day

Hospital, institution, or street address where death occurred:

Montgomery Co. Gen. Hosp.

How long in hospital or institution?.....

1 day

3. (a) FULL NAME

Timothy Grigsby

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

col

single

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Nov 16 1947

8. AGE:

Years

Months

Days

If less than one day

2

16

hrs.

min.

9. Birthplace.....

Olney, Md.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

MOTHER

FATHER

12. Name.....

Bob Grigsby

13. Birthplace.....

Va

14. Maiden name.....

Frances Edwards

15. Birthplace.....

Va

16. Informant.....

Hosp. Records

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof

Jul 3. 1948

(month) (day) (year)

Cemetery or cemetery

Family Burial lot

Location

Greenville, Va, Sanquicarlo

18. Funeral director.....

Roy W. Barber

Address

Goffstown, Md.

19. Date rec'd by registrar

Feb. 3 1948 Detudek-Lawler

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Montgomery

City or town.....

Rockville

County.....

Montgomery

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 2 1948 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

dysentery to 19. and that I last saw him alive on 19.

Immediate cause of death.....

1st 2nd - & 3rd degree burns involving face, hands, and

Due to: (accident) (accident)

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Jul 3. 1948 Date of 2-1-48

Where did injury occur?..... Rockville, R.F.D. County Montgomery State Md.

Injured at home, farm, industry, public place (where?)..... home

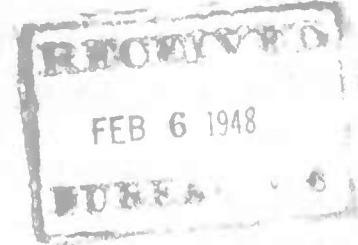
Means of injury..... home burned Injured at work? no

23. SIGNATURE.....

D. S. M. D. or other

Address.....

Smithsburg, Md. Date signed 2-2-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01808

216

Reg. Dist. No.

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 28 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution?..... 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D.C. County..... Washington
City or town..... (If outside city or town limits, write RURAL and give nearest town)
Street No..... 527 Ingraham St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war..... Sp.Am.War

3. (a) FULL NAME

GROSS, Clyde Ernest

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife.....
..... 6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.)..... March 4, 1878

8. AGE: Year	Months	Day	If less than one day
69	10	29 hrs. min.

9. Birthplace..... Pa. (Town, county, and state)

10. Usual occupation..... Retired Gov't. Employee

11. Industry or business.....

12. Name..... unknown	13. Birthplace..... unknown
-----------------------	-----------------------------

14. Maiden name..... unknown	15. Birthplace..... unknown
------------------------------	-----------------------------

16. Informant..... daughter: Mrs. Esther M. Sheppard

Address..... 527 Ingraham St., N.W., Wash., D.C.

17. Burial..... Date thereof..... 2-6-48
(Burial, cremation, or removal, Which?) (month) (day) (year)
Arlington National Cemetery or crematory

Location..... Arlington, Va.

18. Funeral director..... S. H. HTNES *Hes.*

Address..... 2901 14th St., N.W., Wash. D.C.

19. Date rec'd by registrar..... 2-3-48 Mary C. Patterson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 3 February 1948 at 2:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 January 1948 to 3 Feb. 1948

and that I last saw him alive on _____

Immediate cause of death..... Bronchitis pneumonia

DURATION

Due to.....

Due to.....

Other conditions..... Pneumonia, Bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations..... confirmed

Date of op.

Autopsy results..... as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

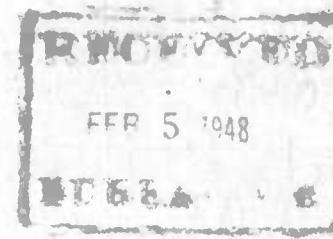
Injured at work?

23. SIGNATURE..... P. L. BATES LT. JG MC USN

M. D. or other

Address..... USNH Bethesda, Md.

Date signed..... 2-3-48



FFR 5 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01809

1068

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County... Montgomery
City or town... Rockville -
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 years

Hospital, institution, or street address where death occurred:
R.F.D. - Rockville Pike - Rockville

How long in hospital or institution?

3. (a) FULL NAME

John Richard Harris

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Mary Jane Harris

7. Birth date of deceased (mo., day, yr.)

March 5-1860

6.(c) If alive, give age 88 years

8. AGE:

Years 87 Months 11 Days 8 If less than one day hrs. min.

9. Birthplace

Potomac - Montg Co - Md

(Town, county, and state)

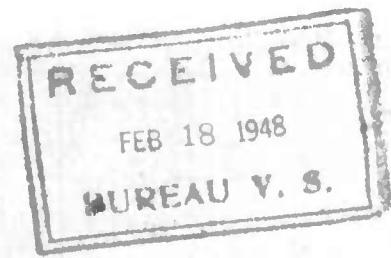
10. Usual occupation

Painter - Stone Mason

11. Industry or business

James Harris

Maryland



I

W
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age.
It is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01810

213

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH

County

City or town

Rockville, Md. B.F.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William H. Hebron

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

Colored

Married

Bessie Hebron

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 9, 1870

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

Dawsonville, Md.

10. Usual occupation

Laborer

11. Industry or business

Patrick Hebron

MOTHER FATHER

12. Name

Montgomery Co. Md.

13. Birthplace

Amelia Coates

14. Maiden name

Montgomery Co. Md.

15. Birthplace

Jessie Hebron (Son)

16. Informant

Rockville, Md.

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 12, 1948

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

19.

E.P. Thompson
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Maryland County

City or town Rockville, Md. B.F.D.

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 10 1948 at 2 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 14 1947 to Feb. 9 1948

and that I last saw him alive on Feb. 9 1948

Immediate cause of death

Hemiplegia left side

Due to

Hemorrhage of Brain

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

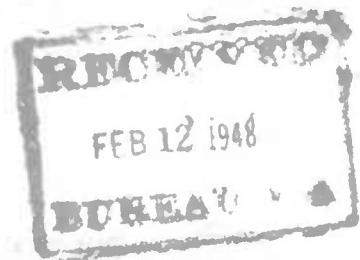
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Youngstown, Pa. Date signed Feb. 10, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01811
216

1. PLACE OF DEATH: Montgomery
 County.....
 City or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? & 9 hours
 Hospital, institution, or street address where death occurred:
 US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 D.C. County.....
 City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
 Street No. 3546 T St., N.W.
(If rural, give LOCATION)
 2.(a) If veteran, name war. WWI

3. (a) FULL NAME HENDERSON, Herbert George

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	separated (10 yrs.)

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 14, 1894

6.(c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
53	5	25	hrs. min.

9. Birthplace..... Washington, D.C.

(Town, county, and state)

10. Usual occupation..... turck driver

11. Industry or business.....

MOTHER FATHER	12. Name..... HENDERSON, Roderick John
	13. Birthplace..... Wash., D.C. dec.
	14. Maiden name..... SAUL, Annie Marion
	15. Birthplace..... Md.

16. Informant..... Mother: Mrs. Annie M. Henderson

Address 3546 T St. N.W., Wash., D.C.

17. burial Date thereof 2-12-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Arlington National

Location..... Arlington, Va.

18. Funeral director..... W. W. CHAMBERS CFB

Address..... Georgetown, D.C.

19. 2-10 48 Mary C. Patterson
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 9 1948 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9 Feb. 1948 to 9 Feb. 1948

and that I last saw him alive on Def Med Train Case
 Immediate cause of death Lobar pneumonia
with Hemoptysis
 Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Data of op.

Autopsy results Same as above

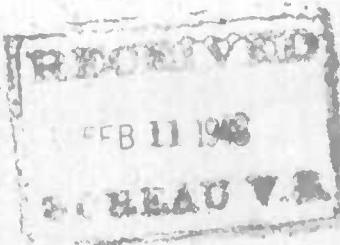
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
 Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Name of injury Frank J. Broschart M.D. Injured at work?23. SIGNATURE Frank J. Broschart M.D., Deputy Medical Examiner M.D. or otherAddress Gaithersburg, Md. Date signed 2-10-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County... Montgomery

City or town... Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 1 day

3. (a) FULL NAME

HIGHTMAN, John Roy

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

Married

6.(b) Name of husband or wife

Eleanor M. Hightman

7. Birth date of deceased (mo., day, yr.)

September 10, 1878

6.(c) If alive, give age — years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Burkettsville, Maryland

(Town, county, and state)

10. Usual occupation

Not available - Retired

11. Industry or business

Same as above

MOTHER FATHER

12. Name

Martin Hightman

13. Birthplace

Maryland

14. Maiden name

Loretta Arnold

15. Birthplace

Virginia

18. Informant

Charts and Records - Wash. San. & Hosp.

Address

700 Carroll Avenue, Takoma Park, Md.

17. Burial

Date thereof Feb 21-1948

(Burial, cremation, or removal which?)

(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

Prince George's County

18. Funeral director

D. S. Fine Co.

Address 2901 14th St. Wash. D.C.

19. Date rec'd by registrar

Feb 19, 1948

John D. D.

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

District of Columbia County None

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6200 - 13th St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 19 1948 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1 1947 to Feb 19 1948

and that I last saw him alive on Feb 18 1948

Immediate cause of death

coronary occlusion

DURATION

36 hrs

Due to

coronary sclerosis

1 year

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

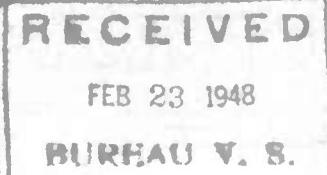
Injured at work?

23. SIGNATURE

Daniel B Washington MD

M.D. or other

Address 6234 7th Ave, Wash DC Date signed 2/19/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01813

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... 2 months, 10 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?... 2 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C.

County...

City or town... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3342 Baker St., N.E.

(If rural, give LOCATION)

WWI

2.(a) If veteran, name war...

3. (a) FULL NAME

HOLMES, George Edward

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife... Harriet Holmes

7. Birth date of deceased (mo., day, yr.) June 14, 1888

6.(c) If alive, give age.....years

8. AGE: Years Months Days If less than one day

59 7 28

9. Birthplace... Washington, D.C.

(Town, county, and state)

10. Usual occupation... Painter

11. Industry or business... *Adeno Carcinoma*

12. Name... HOLMES, Henry dec.

13. Birthplace... Wash., D.C.

14. Maiden name... ROBERTSON, Evelyn dec.

15. Birthplace... Wash., D.C.

16. Informant... wife: Mrs. Harriet Holmes

Address 3342 Baker St., N.E., Wash., D.C.

17. Burial Date thereof... 2-14-48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Washington National

Location... Suitland, Md. C.

18. Funeral director... Lee Funeral Home

Address 4th & Mass., Avenue, N.W., Wash., D.C.

19. 2-12 48

(Date rec'd by registrar) Mary C. Patterson

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 February 48 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 Dec. 1947 to 12 Feb. 1948

and that I last saw him alive on 12 February 1948

Immediate cause of death

Due to *Adeno Carcinoma* of LiverDue to *Adeno Carcinoma* of Sigmoid

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation *Adeno Carcinoma* affects sigmoid. Date of op. 5-19-47

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of...

Where did injury occur? (City or town) (County) (State)

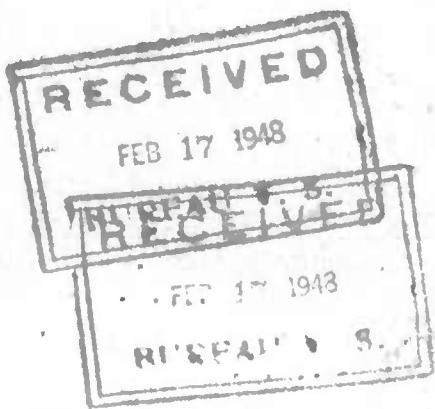
Injured at home, farm, industry, public place (where?)

Means of Injury *J. A. MURPHY* - Injured at work?

23. SIGNATURE J. A. MURPHY, Cdr MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 2-12-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death clearly and legibly
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01814

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 714

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1530 Red Oak Drive

How long in hospital or institution?

3. (a) FULL NAME

MARGARET L. HOLZ

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

female

white

married

6.(b) Name of husband

~~Emil H. Holz~~

6.(c) If alive, give age years

7. Birth date of deceased (mo. day. yr.)

Nov. 6, 1896

8. AGE:

Years

Months

Days

If less than one day

51

3

1

hrs.

min.

9. Birthplace Washington, D. C.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own Home12. Name William E. Dixon13. Birthplace Washington, D. C.14. Maiden name Margaret A. Garrison15. Birthplace Washington, D. C.16. Informant Mrs. Paul Berkeley, daughter D.C.Address 1238 Van Buren St., N. W., Washington,17. Burial Date thereof Feb. 9, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar Hill SanctuaryLocation Suitland, Md.18. Funeral director Waxner & Pumphrey
S.C.P.Address Silver Spring, Md.19. 744-8 19-48 Josephine Schaeffer
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty MontgomeryCity or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1530 Red Oak Drive

(If rural, give LOCATION)

2.(a) If veteran, name war. ---

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 7

1948

A.M. or P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep. med. Socia care

19..... to 19.....

and that I last saw h. alive on

19.....

Immediate cause of death

Coronary occlusion

Due to

Frank

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

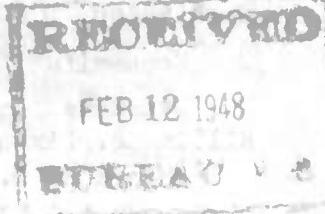
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Broshart M.D.
Dep. med. Exam M. D. or otherAddress Guthersburg, Md. Date signed 2-8-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

01815
Y14

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Montgomery
 City or town..... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
708 Sligo Ave.

How long in hospital or institution?

3. (a) FULL NAME

Isaac Elsworth Keiser

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	widowed

6. (b) Name of husband or wife..... Alice R.

7. Birth date of deceased (mo., day, yr.) Aug. 1st. 1862

8. AGE: Years	Months	Days	If less than one day
85	6	4	hrs. min.

9. Birthplace..... Ohio
(Town, county, and state)

10. Usual occupation..... Retired

11. Industry or business

12. Name..... Daniel Keiser

13. Birthplace..... Ohio

14. Maiden name..... Unknown Overholtz

15. Birthplace..... Unknown

16. Informant..... Rhetta Keiser Ammann

328 American Ave.

Address..... Long Beach # 2, Cal. Date thereof..... Feb. 13, 1948
(Burial, cremation, or removal. Which?)17. Cremation..... Cemetery or crematory..... Cedar Hill Crematory
Location..... Suitland, Prince Geo. Co., Md.18. Funeral director..... Warner E. Pumphrey
Address..... Silver Spring, Md. E.C. #19. Date rec'd by registrar..... 2/13/48 Joseph M. Schaeffer
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No..... 708 Sligo Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war..... no

3. (b) Social Security Number
none

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 5, 1948 at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17, 1940, to 2-5-48
and that I last saw h. s. alive on 2-4-48

Immediate cause of death

Cachexia and malnutrition

DURATION
2 months.

Due to..... Senility & generalized arteriosclerosis

10 years

Due to..... Chronic nephritis

5 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

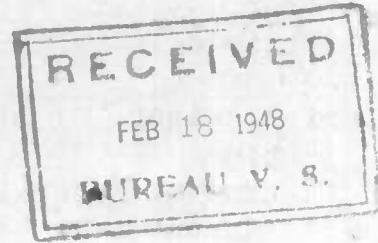
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE..... W. Schaeffer, M.D.

M. D. or other
Address..... 8005 Woodbury Drive
Silver Spring, Md. Date signed..... 2/5/48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

308

01816
218

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County

Montgomery

City or town

Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred:

Montgomery County General Hospital

How long in hospital or institution? 6 wks

3. (a) FULL NAME

JAMES W. KESSELL

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white Married

6. (b) Name of husband or wife

Oliver Kessell

7. Birth date of deceased (mo., day, yr.)

April 4, 1879

6. (c) If alive, give age years

8. AGE:

Years
68Months
10Days
10If less than one day
hrs. min.

9. Birthplace

Hardy County, West Virginia

(Town, county, and state)

10. Usual occupation

Machine Tool Worker

11. Industry or business

None

MOTHER FATHER

12. Name

James Kessell

13. Birthplace

West Virginia

14. Maiden name

Elizabeth Thom

15. Birthplace

West Virginia

16. Informant

Hospital Recorder

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof
(month) (day) (year)
2/16/48

Cemetery or crematory

James Memorial Cemetery

Location

Cumberland, Md.

18. Funeral director

Wm. Wright

Address

Cumberland, Md.

19. Feb 14 1948 Address of Coroner

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Montgomery

City or town

Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 14, 1948 at 5:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 3, 1948, to Feb 14, 1948,
and that I last saw him alive on Feb 14, 1948.

Immediate cause of death

Tubo-pneumis

DURATION

6 months

Due to

Due to

Other conditions

Suppultate Ovaritis

Bleeding External hemorrhoids

(Include pregnancy within 3 months of death)

22 yrs

3 months

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

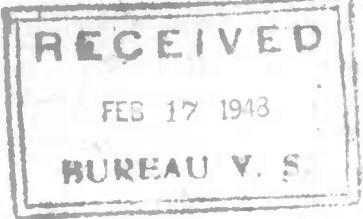
Address

Sandy Spring, Md.

M. D. or other

Date signed

Feb 14/48





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

01817

2/14

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring (Rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? one yearHospital, Institution, or street address where death occurred
RFD 2 Briggs Chaney & Colvinville Rd.

How long in hospital or institution?

3. (a) FULL NAME

Stephen Gerard

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. RFD 2

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

malewhitemarriedIsabelle V King

B.(b) Name of husband or wife.....

6. (c) If alive, give age 78 years

7. Birth date of deceased (mo., day, yr.)

Apr. 30, 1864

8. AGE:

Years 83 Months 10 Days 18 If less than one day

hrs. min.

9. Birthplace.....

Lemontown, St. Marys, Md.

(Town, county, and state)

10. Usual occupation.....

retired

11. Industry or business

MOTHER FATHER

12. Name John F King13. Birthplace Lemontown, St. Marys, Md.

14. Maiden name.....

Hagelton15. Birthplace Lemontown, St. Marys, Md.

16. Informant.....

John F King

Address

RFD 2 - Briggs Chaney & Colvinville Rd.Silver Spring, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 19, 1948

(month day year)

Cemetery or crematory

St. AlphonsusLemontown, Md.

Location

Joseph L. Mattingly

18. Funeral director.....

Lemontown, Md.

Address

Joseph L. Mattingly

19. Date rec'd by registrar

Feb. 19, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. RFD 2

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Feby 19 194821. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feby 19 1948 to Feby 19 1948and that I last saw him alive on 2 am, Feby 19 1948

Immediate cause of death.....

Coronary occlusion

DURATION

24 hrs.

Due to.....

Due to.....

Other conditions No history of other conditions

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE

John N. Andrews

M. D. or other

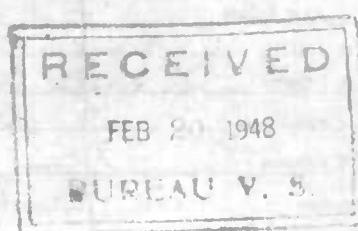
Address 9601 Colesville RdDate signed Feby 19 1948

MEMORANDUM

TO: DIRECTOR, FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

FROM: DIRECTOR, FEDERAL BUREAU OF INVESTIGATION

RE: TELEGRAMS TO AND FROM THE STATE DEPARTMENT



44-1819-42

lens

missed it

2nd or 3rd

1st or 2nd

not found

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01818

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County

Montgomery Park

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

11 Columbia Ave

How long in hospital or institution?

3. (a) FULL NAME

Edward Quintus Knight

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M.

W.

Married

Edith S. Knight

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

Sept. 16 - 1871

8. AGE:

Years

Months

Days

If less than one day

76 4 22 hrs. min.

9. Birthplace

(Town, county, and state)

Montgomery - MD

10. Usual occupation

Retired Government

11. Industry or business

FATHER

12. Name

Casperus Knight

13. Birthplace

Buffalo

MOTHER

14. Maiden name

Mary Simpson

15. Birthplace

Black Rock - New York

16. Informant

Mrs. Edith S. Knight

Address

11 Columbia Ave - Home

17. Cemetery or crematory

Cemetery

Date thereof

Date thereof Sept. 1948

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cedar Hill Crematory

Location

Princip George County

18. Funeral director

Future Death

Address

254 Carroll Avenue

19. Date rec'd by registrar

Feb 18 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.

City or town Jerome Park (If outside city or town limits, write RURAL and give nearest town)

Street No. 11 Columbia Ave - Home

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9 1948 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med Exam case 19 to 19

and that I last saw h. alive on 19

Immediate cause of death

Coronary occlusion

Due to

Cerebral accident

Other conditions Atrial - ectopics

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Broschart M.D.

Deceased Exam M. D. or other

Address 223 2-9-48 Date signed



01819

MARYLAND STATE DEPARTMENT OF HEALTH A

2411 N. Charles St., Baltimore

52a

CERTIFICATE OF DEATH

214

Reg. Dist. No.

1. PLACE OF DEATH:
 County Montgomery
 City or town Silver Spring (If outside city or town limits, write RURAL and give nearest town)
 Now long in above place of death? Two months
 Hospital, institution, or street address where death occurred: 9714 Colesville Road.
 Now long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Virginia County Fairfax
 City or town Glen Clifton (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.F.D. (If rural, give LOCATION)

3. (a) FULL NAME Richard Montimore La Roche

3. (b) Social Security Number —

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married.

6. (b) Name of husband or wife Pauline

7. Birth date of deceased (mo., day, yr.) November 20, 1906 6. (c) If alive, give age 39 years

8. AGE: Years 41 Months 2 Days 19 If less than one day — hrs. — min. —

9. Birthplace Washington, D.C. (Town, county, and state)

10. Usual occupation Librarian

11. Industry or business Library of Congress

MOTHER FATHER 12. Name William Montimore La Roche

13. Birthplace Charleston, S.C.

14. Maiden name Garrison Parker

15. Birthplace Culpepper, Virginia - wife

16. Informant Burial Date thereof Feb. 11, 1948
 (Burial, cremation, or removal. Which?)

Cemetery or cemetery National Memorial Park
 Location Falls Church, Va.

18. Funeral director Maxine E. Cumphrey

Address Silver Spring, Md.

19. Date rec'd by registrar Feb. 10, 1948 Josephine Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 2-8-48 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15, 1947 to 2-8-48

and that I last saw him alive on 2-8- 1948

Immediate cause of death Hypernephroma Right Kidney DURATION one year

Due to Generalized Carcinomatosis 5 weeks

Due to —

Other conditions —

(Include pregnancy within 8 months of death)

Major findings of operations Carcinoma Rt. Kidney with Metastases Date of op. 12-4-47

Autopsy results not done —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

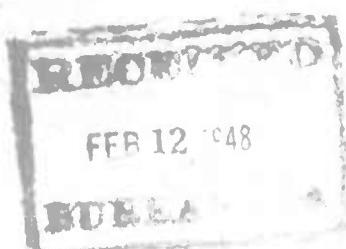
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mr. Sherman Parker Dr. or other Physician

Address 8005 Woodbury Drive, Silver Spring, Md. Date signed Feb. 8, 1948



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

01820

2/6

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 1 yr.
Hospital, institution, or street address where death occurred:..... 620 Pickwick Lane
How long in hospital or institution?..... None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Maryland County..... Montgomery
City or town..... Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 620 Pickwick Lane
(If rural, give LOCATION) None
2.(a) If veteran, name war.....

3. (a) FULL NAME
Ida Carter Leonard

3. (b) Social Security Number
None

4. Sex Female	5. Color or race White	6.(a) Single, married, widowed, or divorced Widowed
------------------	---------------------------	--

6.(b) Name of husband or wife..... Jesse Leonard

7. Birth date of deceased (mo., day, yr.)..... 6.(c) If alive, give age..... dec. years
September 1st, 1867

8. AGE: Years..... 80 Months..... 5 Days..... 8 It less than one day..... hrs. min.

9. Birthplace..... Alexandria, Ohio
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business..... None

MOTHER FATHER
12. Name..... Rufus R. Carter

13. Birthplace..... Ohio

14. Maiden name..... Martha Ann Wickiser

15. Birthplace..... Ohio

16. Informant..... Mrs. Ray T. Watkins
Address..... Chevy Chase, Maryland

17. Shipment..... Date thereof..... Feb. 10, 1948
(Burial, cremation, or removal. Which?)
Basil, Ohio

Cemetery or crematory.....

Location..... Basil, Ohio

18. Funeral director..... Mr. Reuben Humphrey
Address..... Bethesda, Maryland

19. 2/10/48 1948
(Date rec'd by registrar) 2pm 5 Jolies
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 9 February 1948 at 10:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1947 to 9 Feb 1948

and that I last saw her alive on 9 February 1948

Immediate cause of death..... Diabetes Mellitus
with Diabetic coma & Acidosis

DURATION

5 yrs

48 hrs

Due to..... Cause unknown

Due to.....

Other conditions..... Gangrene, diabetic, left foot. 1 month
Quadriplegia, Arteriosclerosis, general 5 yrs.
(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. _____

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of _____

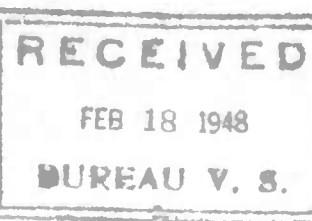
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE..... Stewart Blaff, M.D.

M. D. or other _____
Address..... 3921 Ingman St. N.W. Wash. D.C. Date signed 9 Feb '48



M PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age.
I WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of
residence and addition of
occupation is shown on year 3/5/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

54a

01821

Reg. Distr. No. 216

ADM No. G 114 FEB 19 1948 CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 5 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C.

County..... Virginia

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2901 18th St., N.W., Wash., D.C., Apt. 408

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

MACK, Frank

3. (b) Social Security Number

4. Sex

male	5. Color or race	6.(a) Single, married, widowed, or divorced
	W-US	married

6.(b) Name of husband or wife.....

Clara A. Mack

7. Birth date of deceased (mo. day, yr.)

December 27, 1880 1881

8. AGE:

Years	Months	Days	If less than one day
67	1	15	hrs. min.

9. Birthplace..... Virginia

(Town, county, and state)

10. Usual occupation.....

Unknown Retired Gov't employee

11. Industry or business

12. Name..... MACK, Albert	dec.
13. Birthplace..... Va.	

14. Maiden name..... HUNTER, Mimmi	dec.
15. Birthplace..... Scotland	

16. Informant..... wife: Mrs. Clara A. Mack	
Address..... 2901 18th St., N.W., Wash., D.C. Apt. 408	

17. burial	Date thereof..... 2-10-48
(Burial, cremation, or removal. Which?)	(month) (day) (year)

Cemetery or crematory..... Arlington National	
Location..... Arlington, Va.	

18. Funeral director..... Birch Funeral Home	D.L.H.
Address..... 3034 M St., N.W., Wash., D.C.	

19. 2-9	48	many C. Patterson
(Date rec'd by registrar)		

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 8 1948 at 7:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3 Feb. 1948 to 8 Feb. 1948

and that I last saw him alive on 8 Feb. 1948

Immediately cause of death

Bronchopneumonia

Due to

glioma (malignant), right

Due to temporal lobe

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations glioma, right
temporal lobe Date of op. 2-5-48

Autopsy results Confirmed above

PHYSICIAN: Please underlie the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

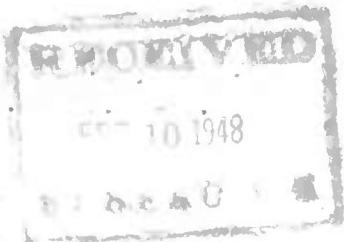
Means of Injury..... Injured at work?

23. SIGNATURE..... S. N. Weaver M.D.

Lt. J.C. MC USNR M. D. or other

USNHS Bethesda, Md. Date signed 2-9-48

Address.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. True cert age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01822

942

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

25 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County..... Montgomery

City or town..... Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 915 Crawford Drive

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

3. (a) FULL NAME

MAJOR, Willard Alexander

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male W-US married
Briarly H. Major

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) September 6, 1892

8. AGE: Years Months Days If less than one day
55 5 9 hrs. min.

9. Birthplace..... Mass. (Town, county, and state)

10. Usual occupation..... unknown

11. Industry or business.....

12. Name..... MAJOR, Wilfred dec.
13. Birthplace..... Mass.14. Maiden name..... LaBLAC, Julia A. dec.
15. Birthplace..... Canada

16. Informant..... Wife: Mrs. Briarly H. Major

Address..... 915 Crawford Drive, Rockville, Md.

17. burial Date thereof..... 1-17-48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Arlington National
Location..... Arlington, Va.18. Funeral director..... W. W. CHAMBERS
Address..... 1400 Chapin St., N.W., Wash., D.C.19. 2-16 1948 Mary C. Patterson
(Date rec'd by registrar) Mary C. Patterson
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 15 February 1948 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
14 Feb. 1948 to 15 Feb. 1948
and that I last saw him alive on 15 February 1948.

Immediate cause of death..... Coronary Thrombosis

Due to.....

Due to.....

Other conditions.....
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

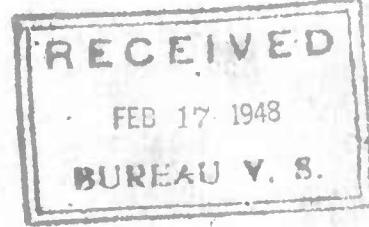
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... H. R. Cooper, Lt. MC USN
M. D. or other

Address..... USNH Bethesda, Md. Date signed..... 2-16-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

018234

CERTIFICATE OF DEATH

Reg. Dist. No. 223

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct and especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 15 days

3. (a) FULL NAME

Mrs. Ruth Dorothy MARKS

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	white American	married

6. (b) Name of husband or wife Mr. William OSCAR MARKS7. Birth date of deceased (mo., day, yr.) MARCH 8, 1902

8. AGE: Years	Months	Days	If less than one day
46	11	21	hrs. min.

9. Birthplace Washington D.C.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name HENRY C. MARKS13. Birthplace Massachusetts14. Maiden name Edna Haislip15. Birthplace Washington D.C.16. Informant Hospital records

Address

17. Burial Date thereof Mar. 3 - 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory First German Cem.Location Prince George Co. Md.18. Funeral director S. A. Hines Co.Address 2901-14th N.W. Washington D.C.19. Date rec'd by registrar March 1 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9000 Flower Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 29 1948 at 12 10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-1-48 to 2-29-48 and that I last saw h. aw alive on 2-29-48.Immediate cause of death Uremia DURATION 10 daysDue to chronic nephritis DURATION 2 yearsDue to the generalized arteriosclerosis DURATION 1 yearOther conditions pneumonia lobare DURATION 1 week

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ruth Dorothy Marks M. D. or other M.D.Address 8005 Woodbury Dr. Date signed 2/29/48

RECEIVED
MAR 3 1948
BUREAU V. S.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01824
94a

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Maryland
City or town Takoma Park M.d.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 days 2 hrs

Hospital, institution, or street address where death occurred:

Washington Sanitarium & HospitalHow long in hospital or institution? 7 days 2 hrs

3. (a) FULL NAME

Thomas Mathieson, Sr.

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married6. (b) Name of husband or wife Martha Mathieson

7. Birth date of deceased (mo. day, yr.)

March 7, 18846. (c) If alive, give age 63 years

8. AGE:

Years	Months	Days	If less than one day	
63	11	25	2	hrs.

9. Birthplace

Scotland

(Town, county, and state)

10. Usual occupation

Builder

11. Industry or business

Cleary Const. Co.

MOTHER FATHER

Robertson & MathiesonScotlandJean HannahScotland

16. Informant

Sanitarium RecordsAddress Takoma Park, Maryland

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof Feb. 14, 1948
(month) (day) (year)Rock Creek CemeteryLocation Washington, D.C.

18. Funeral director

Wm. Andrew HumphreyAddress Bethesda, Maryland19. Feb. 13, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda (If outside city or town limits, write RURAL and give nearest town)Street No. 7434 Wisconsin Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

579-03-3882

MEDICAL CERTIFICATION

2D. DATE OF DEATH

2/11/48 at 1:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1947 to Feb. 11, 1948and that I last saw him alive on Feb. 10, 1948

Immediate cause of death

BRONCHIAL PNEUMONIA

DURATION

3 daysDue to CORONARY THROMBOSIS41 daysDue to GENERALIZED ARTERIOSCLEROSIS5 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As STATED ABOVE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

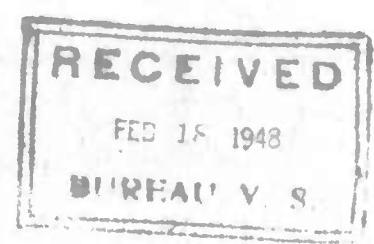
Injured at work?

23. SIGNATURE

Brent. Benjamin, M.D.

M. D. or other

Address Bethesda, Md. Date signed 2/13/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The date of death
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH X

2411 N. Charles St., Baltimore

01825

214

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 28 yrs -

Hospital, institution, or street address where death occurred:..... 751 Shady Ave

How long in hospital or institution?.....

3. (a) FULL NAME

McCAULEY, Miss ENNA DELIA

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced SINGLE

8. (b) Name of husband or wife: -

7. Birth date of deceased (mo., day, yr.) SEPT 9, 1873

8. AGE: Years Months Days If less than one day
74 4 27 hrs. min.

9. Birthplace..... Frankfort, Kentucky

(Town, county, and state)

10. Usual occupation..... Clark - Retired

11. Industry or business..... W. S. Gor. Printing office

12. Name of Father John Robert McCaulley

13. Birthplace..... Madison, Ind.

14. Maiden name..... Rebecca Anna Ellis

15. Birthplace..... Frankfort, Kentucky

16. Informant..... Mr. DeWitt Carr

Address..... 751 Shady Ave. S.S. Md.

17. BURIAL..... Date thereof FEB 9th 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... CEDAR HILL.

Location..... PRINCE GEORGES Co. MD

18. Funeral director..... Warner E. Lumpkin

Address..... SILVER SPRING, MD

19. Date rec'd by registrar..... 1848 Josephus M. Schaeffer
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State..... Maryland County..... Montgomery

City or town..... Silver Spring, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 751 Shady Ave

(If rural, give LOCATION)

2.(a) If veteran, memo war: -

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 5 1948 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
11-19 1945, to 2-5 1948

and that I last saw her alive on 2-4 1948

Immediate cause of death..... Pneumonia

Hypostatic

DURATION

2 days

Due to..... Cancer of Liver (Carcroma) 1 1/2 yrs.
secondaryDue to..... Cancer of Liver (Carcroma)
colon - Carcroma 2 yrs.

Other conditions..... Anemia

2 yrs.

(Include pregnancy within 3 months of death)

Major findings or operations..... Adenocarcinoma of colon
with nearly complete obstruction of op. 2 ft 13-47

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

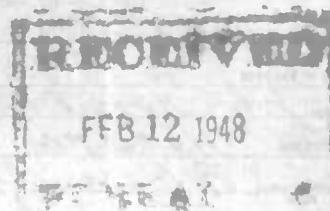
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... B. D. Mitchell, M.D.

M. D. or other

Address..... Silver Spring, Md. Date signed 2-6-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1246
01826

CERTIFICATE OF DEATH

Reg. Dist. No. 2231

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Check age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr.

Hospital, institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 1 hr.

3. (a) FULL NAME

Douglas Stephen McKinney

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

November 4, 1945

8. AGE:

Years

Months

Days

If less than one day

2

3

9

hrs.

min.

9. Birthplace

Washington, D.C.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

12. Name John D. McKinney

13. Birthplace Washington, D.C.

14. Maiden name Druscilla Hartley

15. Birthplace Rhode Island

16. Informant Neal B. McKinney

Address 7203 Cobalt Rd., Wood Acres, Md.

17. (Burial, cremation, or removal) Burial Date thereof 2/17/48

(month) (day) (year)

Cemetery or crematory Fort Lincoln

Location

18. Funeral director Paterson & McKinney

Address Silver Spring

19. Tel. 154-1111 J. W. Wilson Dodd

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1902 Lansdowne Way

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-6-13 1948 at 12⁰⁰ PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9-6-11 1948 to 9-6-13 1948

and that I last saw him alive on 9-6-13 1948

Immediate cause of death

Ac. Respiratory Infection

Due to

Pneumonia

Due to

Fever

Other conditions

Partial atelectasis
Congested Pleuritis

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

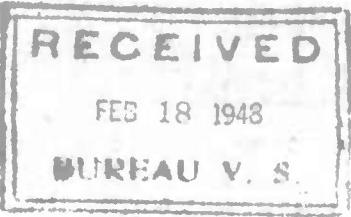
Injured at work?

23. SIGNATURE

John D. McKinney

M. D. or other

Address 2510 Larch Ave. Date signed 9-11-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01827

125a

CERTIFICATE OF DEATH

716

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 13 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County Montgomery

City or town Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (a) FULL NAME

ADELINE MEADS

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Negro Married

6.(b) Name of husband Jessie Meads

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1901

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day

46 3 5 hrs. min.

9. Birthplace Boyd's, Mont. Co., Maryland

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Edward Campbell

13. Birthplace Boyd's, Mont. Co., Maryland

14. Maiden name Sarah Boynes

15. Birthplace Boyd's, Mont. Co., Maryland

16. Informant Sarah Meads (daughter)

Address Rockville, Md

17. Burial Date thereof Feb. 29, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St Marks

Location Boulders, Maryland

18. Funeral director R. L. Swanson

Address Rockville, Maryland

19. 2/27/48 Reg. No. E. J. Jones

(Date rec'd by registrar)

Reg. No. 2

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 26, 1948, at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med. Steam case
and that I last saw h. alive on 19.....

Immediate cause of death

Acute yellow straphy of
The lita

Duration 2x hrs

Cause of death Extensive fresh hemorrhage

of the lungs (not due to Tuberculosis)
(4/6/48-AS)

Other conditions Pulmonary edema

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

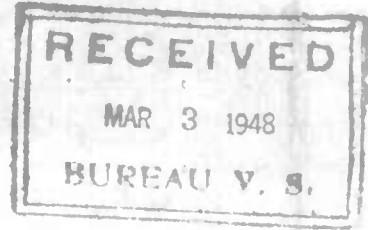
Injured at work?

23. SIGNATURE Frank J. Borchart M.D.

Dep. J. J. Stans

M. D. or other

Address Gaithersburg, Md. Date signed 2-28-48



MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

01828

1. PLACE OF DEATH

County MontgomeryVillage or City BethesdaSuburb No. 1000 hospitalSt. 216

Ward

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME

Joseph D. Mitchell(a) Residence: No. 13908 Olivier St Chevy Chase Maryland
(Usual place of abode)

If U. S. Veteran, specify WAR

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED,
OR DIVORCED (write the word)5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day, and year)

7. AGE Years Months Days If LESS than
82 82 1 18 1 day, _____ hrs.
or _____ min.8. Trade, profession, or particular
kind of work done, as SPINNER,
SAWYER, BOOKKEEPER, etc.Bookbinder9. Industry or business in which
work was done, as SILK MILL,
SAW MILL, BANK, etc.10. Date deceased last worked at
this occupation (month and
year)11. Total time (years)
spent in this
occupation12. BIRTHPLACE (city or town)
(State or country)13. NAME John Mitchell14. BIRTHPLACE (city or town)
(State or country)15. MAIDEN NAME Follen Heard16. BIRTHPLACE (city or town)
(State or country)17. INFORMANT J. Hoyt. Records
(Address)18. BURIAL, CREMATION, OR REMOVAL
Place McClures Cemetery Nash. DC
Date 1919. UNDERTAKER Funerary Standard
(Address) 641 - 7th & N.W.20. FILED 2/8/19 Wm E. Jones
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

February

8

1948

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY, That I attended deceased from

April 7, 1946, to Feb. 8, 1948.

I last saw him alive on Feb. 7, 1948; death is said
to have occurred on the date stated above, at 6:30 A.M.The PRINCIPAL CAUSE OF DEATH and related causes of importance
were as follows:Cerebral Hemorrhage

Date of onset

3/28/48

Other Contributory Causes of Importance:

HypertensionName of operation none

Data of

What last confirmed diagnosis?

Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? no Data of Injury 19Where did injury occur? no

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury noNature of injury no24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signature) W. B. Jones M. D.
(Address) Takoma Park, Md.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerosis	1915
Chronic interstitial nephritis	1921
Cerebral hemorrhage	July 5, 1927

Example II

The principal cause of death and related causes of importance were as follows:

Attack of epilepsy	Date of onset 1 week ago
Run over by street car	1 week ago
Peritonitis	3 days ago

FEB 12 1948

Other contributory causes of importance:

Gallstones	May 1, 1928

Other contributory causes of importance:

Gastroenteritis	1 year

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01829

CERTIFICATE OF DEATH

Reg. Dist. No. 223

M
I
T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 Hours

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 24 Hours

3. (a) FULL NAME

Mr. Ralph Donald Monard

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White

married

6.(b) Name of husband or wife Mrs. Elsie Jane Monard

7. Birth date of deceased (mo. day, yr.)

August 7, 19226.(c) If alive, give age 19 years

8. AGE:

Years

Months

Days

If less than one day

25

6

15

hrs.

min.

9. Birthplace

Dickerson Maryland

(Town, county and state)

10. Usual occupation

(not employed)

11. Industry or business

12. Name Lewis Monard13. Birthplace MD14. Maiden name NETTIE15. Birthplace MD16. Informant Mrs. ELSIE JANE MONARDAddress BREIGS CHANEY RD - SILVER SPRING MD

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof FEB - 25 - 1948
(month) (day) (year)Cemetery or crematory COLESVILLE CHURCHLocation COLESVILLE MONTG CO MD18. Funeral director Moine & Cumpsty m.Address SILVER SPRING MD19. Feb 27 1948
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty MONTGOMERYCity or town Silver Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

217-16-2870

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-22-48

19.

at 11:32 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 1946 19... to 2/22/48 19...and that I last saw h. m. alive on 2/22/48.

Immediate cause of death

Incurable asthma of brain
metastatic prostatic tumor

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Partial ph. Hopkins Deep
Sept 4 - 1946

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

G

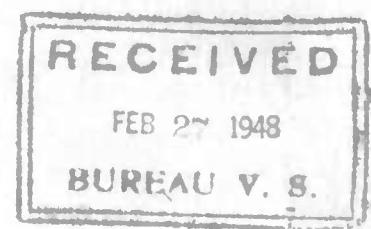
Injured at work?

23. SIGNATURE

John D. Monard

M. D. or other

825 Colesville RdDate signed 2/22/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01830

CERTIFICATE OF DEATH

Reg. Dist. No.

316

1. PLACE OF DEATH:

County Montgomery

City or town R.F.D. - Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Years

Hospital, institution, or street address where death occurred:

6104 MacArthur Blvd.

How long in hospital or institution?

3. (a) FULL NAME

LUCY HOLBROOK MOORE

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Married

6. (b) Name of husband or wife Henry Frank Moore

6. (c) If alive, give age 80 years

7. Birth date of deceased (mo. day, yr.) May 11, 1871

8. AGE: Years Months Days It less than one day
76 76 9 13 hrs. min.9. Birthplace Providence, Rhode Island
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

12. Name Unknown Baxter

13. Birthplace Unknown

14. Maiden name Unknown Snow

15. Birthplace Unknown

16. Informant Henry Frank Moore

Address R.F.D., Bethesda, Maryland

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Feb. 27, 1948

Cemetery or crematory Nat'l Memorial Park

Location Fairfax, Virginia

18. Funeral director Wm. Julian Murphy

Address Bethesda, Maryland

19. Sept. 26, 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town R.F.D. - Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 6104 MacArthur Blvd.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 27, 1948 at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical Examiner's Office

and that I last saw h. . . . alive on

Immediate cause of death

Coronary occlusion

DURATION

1/2 hour

Due to chronic arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

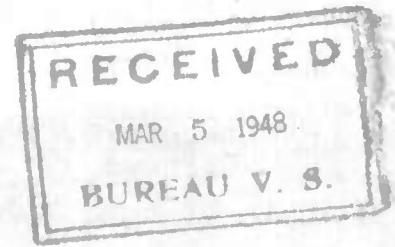
Injured at work?

23. SIGNATURE E.G. Bauerfield, M.D.

Medical Examiner, Dept. of Health, Bethesda, Md.

M. D. of other

Address Date signed 2-24-48





MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01832

CERTIFICATE OF DEATH

Reg. Dist. No. 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County... Montgomery

City or town... Chevy Chase 14d

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?... LIFE

Hospital, institution, or street address where death occurred:

#1 Kenilworth Dr., Chevy Chase, Md.

How long in hospital or institution?

3. (a) FULL NAME

CHARLES EIRICH NORRIS

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

M.

W

MARRIED

6.(b) Name of husband or wife

Mary A.

7. Birth date of deceased (mo., day, yr.)

Jan 20, 1870

6.(c) If alive, give age..... 1870 years

8. AGE:

Years
78 80

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

Maryland

(Town, county, and state)

10. Usual occupation

Landscape Gardner

11. Industry or business

MOTHER FATHER

12. Name.....

John W. Norris

13. Birthplace.....

Maryland

14. Maiden name.....

Charlotte Kingston

15. Birthplace.....

Maryland

16. Informant.....

Allen M. Norris

Address

#1 Kenilworth Dr., Chevy Chase, Md.

17. Burial

Date thereof... Feb 13, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Wash. National Cem. Md.

Location

Southland, Md.

18. Funeral director

W.W. Chambers Co.

Address

3072 M St. N.W. Wash. D.C.

19. (Date rec'd by registrar)

2/11/48 Wm & Jones

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. #1 Kenilworth Dr.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB 10 1948 at 10:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

JUN 1945 to FEB 10 1948

and that I last saw h.i.m. alive on FEB 10 1948

Immediate cause of death

PULMONARY EDEMA

Due to HYPEREXTENSION

Due to CEREBRAL VASCULAR

HEMORRHAGE

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

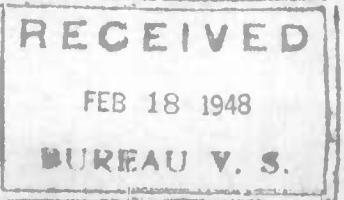
Injured at work?

23. SIGNATURE P.P. Andrews M.D.

M. D. or other

Address 4201 Euclid St. N.W. Wash. D.C.

Date signed 2/11/48



Evidence for change of
birth date and age shown
on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILE NO. G 111 MAR 17 1948

100-
01833
216

Reg. Dist. No.

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County... Montgomery

City or town... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 6 days

Hospital, institution, or street address where death occurred:

US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 months, 6 days

3. (a) FULL NAME

OLIVER, George Alfred

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male

W-US

married

Gertrude C. Oliver

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

November 6, 1914

8. AGE:

Years
33

Months
3

Days
18

If less than one day

hrs.

min.

9. Birthplace

Va.

(Town, county, and state)

10. Usual occupation

Dept. of School grounds

11. Industry or business

Modern School, Fairfax Co., Va.

MOTHER

FATHER

12. Name

OLIVER, Harry L.

MOTHER

FATHER

13. Birthplace

Va.

14. Maiden name

DOWNEY, Annie

D.C.

15. Birthplace

wife: Mrs. Gertrude C. Oliver

16. Informant

Vienna, Va., Rt. #1

Address

burial

Date thereof Feb. 27, 1948
(month) (day) (year)

17. (Burial, cremation, or removal. Which?)

Salem Cemetery

Cemetery or crematory

Forestville, Va.

Location

O. C. Pearson

O. C. P.

18. Funeral director

Address Falls Church, Va.

2-25

48

Mary C. Patterson

19. (Date rec'd by registrar)

19

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Va.

County

Vienna

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Route #1

(If rural, give LOCATION)

2.(a) If veteran, name war

WWII

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 24 February 1948 at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 18, 1947, to 24 Feb. 1948

and that I last saw h. in alive on 24 Feb. 1948

Immediate cause of death

Embolism (Pulmonary)

DURATION

24 hrs.

Due to Thrombosis, Pelvic Veins

2 mos.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

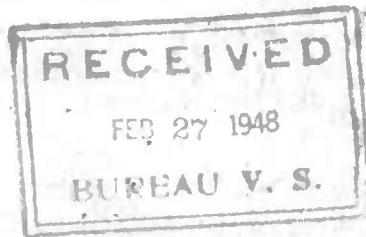
Injured at work?

23. SIGNATURE H.R. Cooper

H.R. COOPER, LT. MC USN, or other

Address USNH Bethesda, Md.

Date signed 3-25-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. It is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160a/

CERTIFICATE OF DEATH

01834
216

Reg. Dist. No.

1. PLACE OF DEATH:

Montgomery

County.....

(Rural) Bethesda, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, Institution, or street address where death occurred:

National Naval Medical Center, Bethesda, Md.

How long in hospital or institution? 1 day

3. (a) FULL NAME

Paiste, Felix Andrew

4. Sex

5. Color or race

B.(a) Single, married, widowed, or divorced

M

W

S

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) 2-20-48

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
22 hrs. min.

9. Birthplace Bethesda, Montgomery, Maryland

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

Felix A. Paiste

13. Birthplace Ohio

14. Maiden name Elizabeth Exline

15. Birthplace Kansas

16. Informant father: Mr. Felix A. Paiste

Address 2415 E. St., N.W., Wash., D.C.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Feb. 23, 1948

(month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va.

18. Funeral director P.J. SAFFELL

Address 475 H St. NW Washington, D.C.

19. 2-21 1948 Mary C. Patterson

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash., D.C. County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 2415 E. St., NW

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 48 19 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
20 Feb. 48 19 21 Feb. 48 19

and that I last saw him on 21 February 19 48

Immediate cause of death Intracranial hemorrhage # 3133 DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

confirmed above

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

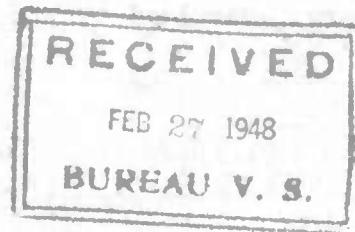
Injured at work?

23. SIGNATURE

J. T. FOWLER, Jr., Cdr. MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 2-21-48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01835
93d

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 daysHospital, institution, or street address where death occurred: washington San. & Hosp.How long in hospital or institution? 20 days, 6 hrs. 35 min

3. (a) FULL NAME

Mrs. Nellie Parotter

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

white

widow

B. (b) Name of husband or wife

George W. Parotter10-14-1877

6. (c) If alive, give age years

Oct. 14, 1877

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years

Month

Day

If less than one day

hrs.

min.

9. Birthplace

washington D.C.

(Town, county, and state)

10. Usual occupation

House wife

11. Industry or business

MOTHER FATHER

12. Name

Washington, DC.

13. Birthplace

Nellie Lock

14. Maiden name

washington, DC.

15. Birthplace

washington, DC.

16. Informant

Son - Wm. L. Staffel

Address

128 Carroll st. S.E., DC.

17. Burial -

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

W.W. Chambers Co

18. Funeral director

517-11th st. S.E.

Address

517-11th st. S.E.

19. 2-28-

19-48

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State DC

County

City or town washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 128

Carroll st. S.E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

2-2819 Y8 at 11:20A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1219 47 to2-2819 48and that I last saw her alive on 2-28

Immediate cause of death

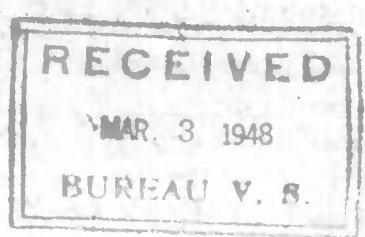
Acute Cardiac Failure

Died of

Hypertension Endocarditis

Due to

Acute Cardiac FailureHypertension EndocarditisAcute Cardiac Failure



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01836
466

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:
Montgomery
 County
 City or town
 (If outside city or town limits, write RURAL and give nearest town)
 Bethesda (rural)
 How long in above place of death?
 26 days
 Hospital, Institution, or street address where death occurred:
 US Naval Hospital, Bethesda, Md.
 How long in hospital or institution?
 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Va. County
 City or town Alexandria
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 810 N. Columbus Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war. WWI

3. (a) FULL NAME

PARKER, Eugene (n.)

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Negro separated

6.(b) Name of husband or wife Pauline Parker

7. Birth date of deceased (mo., day, yr.) December 22, 1884
 6.(c) If alive, give age years8. AGE: Years Months Days If less than one day
 63 2 6 hrs. min.

9. Birthplace Va. (Town, county, and state)

10. Usual occupation unknown

11. Industry or business

12. Name PARKER, Martin ded.

13. Birthplace Va.

14. Maiden name Sarah Hood dec.

15. Birthplace Va.

16. Informant sister: Mrs. Blanch Taylor

Address 214 N. Payne St., Alexandria, Va.

17. burial Date thereof 3-4-48
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director Lloyd A. Lewis J.C.L.

Address 800 Wolfe St., Alexandria, Virginia

19. 2-28 19. 48 Mary C. Patterson
 (Date rec'd by registrar) Registrar**3. (b) Social Security Number****MEDICAL CERTIFICATION**

20. DATE OF DEATH 28 February 19. 48 at 0530 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
 2 Feb. 19. 48 to 28 Feb. 19. 48
 and that I last saw him alive on 28 Feb. 19. 48

Immediate cause of death

Bronchopneumonia

DURATION

48 hrs.

Due to Adenocarcinoma of stomach
 with metastases

2 yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

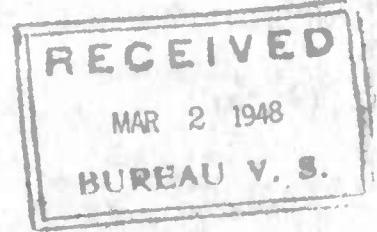
injured at work?

23. SIGNATURE

W. F. HARRISON, Lt. MC USN

USNH Bethesda, Md. M. D. or other 2-28-48

Address Date signed



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01837

Reg. Distr. No. 213

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County

Montgomery
Rockville

City or town.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 mo

Hospital, Institution, or street address where death occurred:

Anderson Ave

How long in hospital or institution?

3. (a) FULL NAME

Helen C. Pearson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white single

6. (b) Name of husband or wife

None

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Apr 2 1944

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Olney Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

Clifford Pearson

12. Name

13. Birthplace

Lena Posey

14. Maiden name

15. Birthplace

Da

16. Informant

Mrs. Clifford Pearson

Address

Rockville Md

17. Burial

Date thereof Feb. 15, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Rockville Union Cemetery

Location

Rockville, Maryland

18. Funeral director

W. Kenneth Murphy

Address

Bethesda, Maryland

19. Date rec'd by registrar

1948

(Date rec'd by registrar)

W. Slougher

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montg.

City or town Rockville (If outside city or town limits, write RURAL and give nearest town)

Street No. Anderson Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 13 1948 at 7:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

def med exam care

19. to 19.

and that I last saw h. alive on

19.

Immediate cause of death

uterine pneumonia

Due to

so attending physician

Due to

so attending physician

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

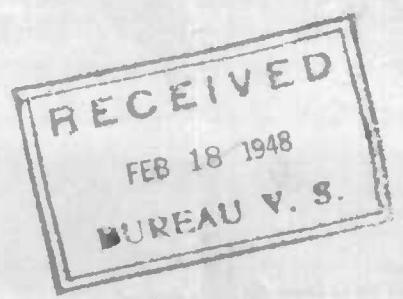
Injured at work?

Troy J. Borchardt M.D.

def med exam

M. D. or other

23. SIGNATURE Address Gathernburg Md Date signed 2-13-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01838

93d

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County **MONTGOMERY**City or town **Bethesda**

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? **SINCE 2-2-48**

Hospital, Institution, or street address where death occurred:

SUBURBAN HOSPHow long in hospital or institution? **SINCE 2-2-48**

3. (a) FULL NAME

SARAH GILLETTE WARD PHELPS

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W^m J. PHELPS

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) **JUNE 24, 1870**

6. (c) If alive, give age years

8. AGE: Years **77** Months Days If less than one day hrs. min. 9. Birthplace **CHICAGO, ILL.**
(Town, county, and state)10. Usual occupation **HOUSE WIFE**

11. Industry or business

12. Name **LORENZO WARD**13. Birthplace **PALMER MASS**14. Maiden name **ELLEN GILLETTE**15. Birthplace **E WINDSOR, CONN**16. Informant **CAPT. CASEY**

Address

17. Cremation Date thereof **2-9-48**
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory **CEDAR HILL**Location **SUITLAND, Md**18. Funeral director **JOE CAWLERS SONS INC**Address **1756 PENN. AVE, N.W.**19. **218** 19 48
(Date rec'd by registrar)20. **Ym E Jones**
Signature
Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State **MD.**

County

MONTGOMERYCity or town **BETHESDA**

(If outside city or town limits, write RURAL and give nearest town)

Street No. **9100 - OLD GEORGETOWN Rd**

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH **Feb 7** 19 48 at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 12 19 47 to **Feb 7** 19 48and that I last saw h. **4** alive on **Feb 7** 19 48Immediate cause of death **Hypertension heart disease** DURATIONDue to **Hypertension**

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results **not done** Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

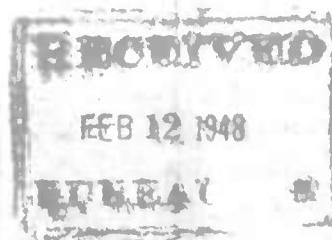
Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Dr. Joseph P. Kuehne** M.D. or otherAddress **7942 Wisconsin Ave, Bethesda, Md** Date signed **2/7/48**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01839

940
Reg. Dist. No. 216

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
 County... Montgomery
 City or town... Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 6 years.
 Hospital, Institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town... Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5603-Park St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

James Roy Pipes

3. (b) Social Security Number

--

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife..... Edith Pipes

7. Birth date of deceased (mo. day. yr.) June 4, 1874

8. AGE: Years	Months	Days	It less than one day
73	7	27	hrs. min.

9. Birthplace..... Cameron, W. Va.

(Town, county, and state)

10. Usual occupation..... Interstate Commerce Commission

11. Industry or business..... U.S. Government

MOTHER FATHER
 12. Name..... James M. Pipes

13. Birthplace..... Penna.

14. Maiden name..... Martha Purdy

15. Birthplace..... W. Va.

16. Informant..... Edith Pipes

Address..... 5603-Park St. Ch. Ch. Md.

17. Burial Date thereof..... 2/5/48
 (Burial, cremation, or removal. Which?) (Month) (Day) (Year)

Cemetery or crematory..... Cedar Hill

Location..... Md

18. Funeral director..... S. H. Hines Co.

Address..... 2901-14th St. N.W.

19. 2/2 1948
 (Date recd by registrar) *Mr E. J. Lee*
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 2/1 1948 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6/23 1946 to 1/23/1948 and that I last saw him alive on 1/23/48 1948

Immediate cause of death..... Coronary thrombosis

Due to..... Coronary artery disease

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE..... *S. H. Hines Co.*

M. D. or other.....

Date signed..... 2/2/48

RECEIVED

FFB 4 1948

FEDERAL BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1576

01840

217

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery
City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

3. (a) FULL NAME

MARY FRANCESPrather

3. (b) Social Security Number

4. Sex Female 5. Color or race Col. 6.(a) Single, married, widowed, or divorced —6.(b) Name of husband or wife —7. Birth date of deceased (mo., day, yr.) February 28, 1948 6.(c) If alive, give age years8. AGE: Years 1 Months 0 Days 0 If less than one day 20 min.9. Birthplace Olney, Montgomery County, Maryland
(Town, county, and state)10. Usual occupation housewife11. Industry or business —12. Name Calvin Roosevelt Prather13. Birthplace Laytonsville, Maryland14. Maiden name Mavis Bernice Zeitzer15. Birthplace Damascus, Maryland16. Informant Hospital recordsAddress Bethesda17. Burial, cremation, or removal? Date thereof March 2, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Friendship mdLocation Montgomery Co. Md.18. Funeral director Bob W. BarberAddress Laytonsville, Maryland19. Date rec'd by registrar 2/28/48 Registrars Ertmude B. Dailey

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Monrovia
(If outside city or town limits, write RURAL and give nearest town)Street No. P.F.D. #1 Near Damascus

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1948 at 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 28, 1948, to February 27, 1948and that I last saw her alive on February 28, 1948Immediate cause of death Spiral Bifida Defecting of Spine DURATION1 hr. 20 min.Due to Bilateral club footDue to —Other conditions —

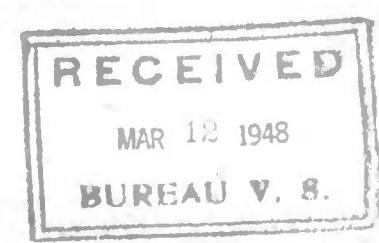
(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State) —Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE James P. Kerr M.D. M. D. or other —Address Damascus, Md. Date signed 3/20/48



I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age.
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

442
b7C/B01841
216

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 3 months, 24 days

Hospital, institution, or street address where death occurred: US Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 3 months, 24 days

3. (a) FULL NAME

RAYGADA, Jullio, Cdr. Peruvian Navy

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

male W Peruvian married

Isabel de Raygada

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo. day, yr.) November 4, 1904

8. AGE: Years 43 Months 3 Days 5 If less than one day hrs. min.

9. Birthplace..... Callao, Peru

(Town, county, and state)

10. Usual occupation..... Peruvian Navy

11. Industry or business

12. Name..... RAYGADA, Jullio

13. Birthplace..... Peru

14. Maiden name..... CARRERA, Genoveva

15. Birthplace..... Peru

16. Informant..... wife: Mrs. Isabel de Raygada

Address..... Peruvian Embassy, Wash., D.C.

17. Transportation Date thereof..... 2-11-48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Baguijano Cemetery

Location..... Callao, Peru

18. Funeral director..... W. W. CHAMBERS

Address..... 1400 Chapin St., N.W., Wash., D.C.

19. 2-10 Date rec'd by registrar..... 19. 48

Mary C. Patterson

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Peru

County.....

City or town.....

Callao

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 9 February 19. 48, at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Oct. 19. 47, to 9 Feb. 19. 48

and that I last saw h. in alive on 9 February 19. 48

Immediate cause of death.....

Choleric nephrosis

DURATION

2 weeks

Due to..... Hodgkin's lymphoma generalized

2 1/2 yrs.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results..... Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work.....

Q. E. Billman 18(73) D. E. BILLMAN, Lt. (jg.) MC USN

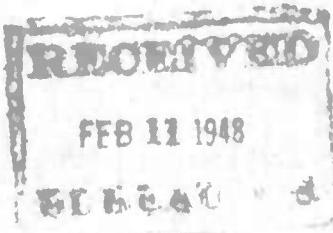
M. D. or other

2-10-48

23. SIGNATURE..... D. E. BILLMAN, Lt. (jg.) MC USN

USNH Bethesda, Md. Date signed.....

Address.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01842

92d

CERTIFICATE OF DEATH

Reg. Dist. No. "L 216

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or Institution? 2 days

3. (a) FULL NAME

READY, Francis Joseph

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) August 7, 1884

8. AGE: Years	Months	Days	If less than one day
63	6	12	hrs. min.

9. Birthplace..... Washington, D.C.
(Town, county, and state)

10. Usual occupation..... Physician

11. Industry or business..... Retired Navy

12. Name..... READY, Morris J.

13. Birthplace..... Wash., D.C.

14. Maiden name..... HEAD, Bertha dec.

15. Birthplace..... Wash., D.C.

16. Informant..... daughter: Mrs. J. W. McGovern, Jr.

Address..... 3325 N St., N.W., Wash., D.C.

17. burial Date thereof..... 2-23-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Mt. Olivet

Location..... Washington, D.C.

18. Funeral director..... P. J. SAFFELL By H. M. Day

Address..... 475 H St., N.W., Wash., D.C.

19. (Date rec'd by registrar) 2-19 1948 Mary J. Patterson Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D.C.	County.....
City or town..... Washington	(If outside city or town limits, write RURAL and give nearest town)
Street No..... 3325 N St., N.W.	(If rural, give LOCATION)

2.(a) If veteran, name war..... W.W.I.

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... February 19 1948 at 2:22 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 17 Feb. 1948 to 19 Feb. 1948 and that I last saw h. in alive on 19 February 1948.

Immediate cause of death..... Hypertensive Heart Disease

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results..... confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

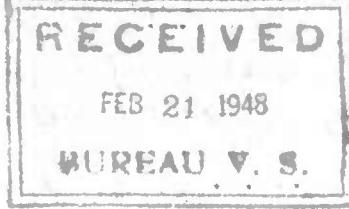
Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... H. R. COOPER, Lt. Lt MC USN

M. D. or other

Address..... USNH Bethesda, Md. Date signed 2-19-48



01843

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County.....

Montgomery

City or town.....

Dawsonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 x yr

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Charles T. Reed

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

W

Married

6. (b) Name of husband or wife.....

Edna Reed

7. Birth date of deceased (mo., day, yr.)

Aug 30 1899

6. (c) If alive, give age..... years

8. AGE:

Years

Month

Day

If less than one day

48

5

14

hrs.

min.

8. Birthplace.....

Herndon, Va

(Town, county, and state)

10. Usual occupation.....

Laborer

11. Industry or business.....

Farm

MOTHER FATHER

Charlotte Reed

13. Birthplace.....

Va

14. Maiden name.....

Charlotte Borders

15. Birthplace.....

Va

16. Informant.....

Mr. Betty Allmuth

Posterville, Md.

Address

17. (Burial, cremation, or removal, which?)

Date thereof.....

Feb 15 1948
(month) (day) (year)

Cemetery or crematory.....

Herndon, Virginia

Location.....

18. Funeral director.....

T. E. Reed & Son

Address

Herndon, Va.

19. 2-15

1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County.....

Montg.

City or town.....

Dawsonville (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Feb 15

1948 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

dyspepsia 19 to 19 and that I last saw him alive on

Immediate cause of death.....

Coronary occlusion

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

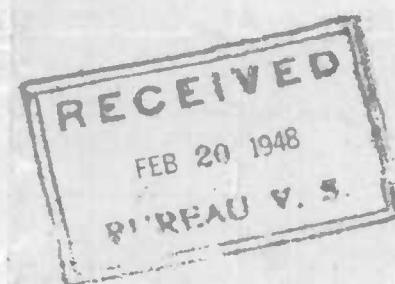
Injured at work?

23. SIGNATURE.....

Dr. Frank J. Grosshart M.D. M. D. or other

Address..... Gaithersburg, Md. Date signed..... Feb 18-48

73673-1
RECEIVED



01844

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

216

Reg. Distr. No.....

W
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)
23 days

How long in above place of death?

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution?

23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1821 Corcoran St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war Sp. Am. War

3. (a) FULL NAME

RICHARDS QN, George

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col-US	single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)
March 4, 1877

8. AGE: Years Months Days If less than one day
70 11 2 hrs. min.

9. Birthplace..... Va.
(Town, county, and state)

10. Usual occupation..... Retired Service Personnel

11. Industry or business

MOTHER FATHER
12. Name..... Richardson, Peter dec
13. Birthplace..... Ga.

14. Maiden name..... BOXLEY, Nancy dec
15. Birthplace..... Va.

16. Informant..... sister: Mrs. Annie Nesley
Address..... 1321 Corcoran St., N.W., Wash., D.C.

17. burial
(Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)
Arlington National Cemetery or crematory.....

Location..... Arlington, Va.
W. Ernest Jarvis *S. M. Jr.*
18. Funeral director
Address..... 1432 U St., N.W., Wash., D.C.

19. *2-6-* 19. 48 Mary C. Patterson
(Date rec'd by registrar) *Registrar*

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 6 February 19 48 at 1:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
13 January 19 48 to 6 February 19 48

and that I last saw him alive on 6 February 19 48

Immediate cause of death

Carcinoma, Naso-pharynx

DURATION

indef.

Due to

Due to

Other conditions..... Metastases to Liver and

Spine; Bronchopneumonia, L.L.

Hypertensive heart disease
(Include pregnancy within 3 months of death)

indef.

Major findings or operations

Date of op.

Autopsy results..... Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

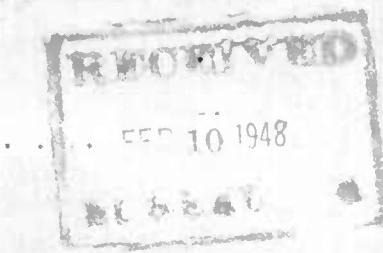
Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE *A. E. Maryland, Jr.* Lt. JG MC USN
M. D. or other

Address..... USNH Bethesda, Md. Date signed 2-6-48



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

87e

01845

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
 City or town Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.How long in hospital or institution? 2 $\frac{1}{2}$ hours

3. (a) FULL NAME

William Preston Rivers

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>Male</u>	<u>White</u>	<u>Single</u>

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) January 31, 1945.

8. AGE:	Years	Months	Days	If less than one day
	<u>3</u>	<u>1</u>	<u>10</u>	hrs. _____ min. _____

9. Birthplace Washington, D.C.
(Town, county, and state)10. Usual occupation. Child

11. Industry or business

12. Name Robert A. Rivers13. Birthplace Cheraw, South Carolina14. Maiden name Julia May Pearce15. Birthplace Galax, Virginia16. Informant Hospital records

Address

17. Burial Date thereof Feb. 14, 1948
(Burial, cremation, or removal. Which?)Cemetery or crematory Colesville Cemetery
 Location Colesville, Md.18. Funeral director Warren E. Pumphrey
S.E.A.P.
 Address Silver Spring, Md.Feb. 17 1948 Entombed B. Lawler
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Sandy Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 100
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 1948 at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Phys med. Exam case to 19
 and that I last saw h. alive on 19

Immediate cause of death

Acidosis
 Due to Gastric paralyse

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank J. Bruchat M.D.
Phys med. Exam

M. D. or other

Address Washington, D.C. Date signed 2-13-48

RECEIVED
MAR 12 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and legibly. It is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

TP 4217

01846

314

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

Montgomery County

City or town.....

Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

7 days

Hospital, institution, or street address where death occurred:.....

Washington Sanitarium & Hospital

How long in hospital or institution?.....

7 days

3. (a) FULL NAME

Mrs. Mary Ruth Rockfield

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Fe Hebrew

Divorced

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo. day, yr.)

6. (c) If alive, give age years

December 2, 1899

8. AGE:

Years Months Days If less than one day

48 2

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Sales Lady

11. Industry or business.....

Solomon Berlin

12. Name

Russia

13. Birthplace

Anna Goldman

14. Maiden name

Russia

15. Birthplace

Records

16. Informant.....

Washington San. & Hosp.

Address

Burial

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)

22 3 1947

Cemetery or crematory.....

Telestarford Cemetery

Location.....

Washington D.C.

Goldberg Funeral Home

Address.....

4217 - 9th St. NW Wash.

19. Date rec'd by registrar.....

Feb. 1, 1948 Josephine Schaeffer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Washington D.C. County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1466 Columbia Rd. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

Feb. 1, 1948 MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Jan 25, 1948, 10:15 a.m. M

and that I last saw her alive on Feb. 1, 1948.

Immediate cause of death..... Terminal hypostasis pneumonia

Due to..... Infants - Pulmonary & bronchitis

Due to..... Metastatic Pg - Vertebra

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

Paul Eane

M. D. or other

Address..... 4847-9th Ave. Date signed..... Feb. 1, 1948

Reg. Dist. No.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01847

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County... Montgomery
City or town... Rural Bethesda, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
National Naval Medical Center, Bethesda, Md.

How long in hospital or institution? 3 days

3. (a) FULL NAME

Ryan, John Augustus

4. Sex M	5. Color or race W	5.(a) Single, married, widowed, or divorced Married
-------------	-----------------------	--

6.(b) Name of husband or wife Mrs. Pauline Ryan

7. Birth date of deceased (mo., day, yr.) August 29, 1873

8. AGE: Years 74	Months 5	Days 23	If less than one day hrs. min.
---------------------	-------------	------------	---

9. Birthplace Penna.
(Town, county, and state)

10. Usual occupation Retired Civil Service

11. Industry or business

12. Name John A. Ryan
13. Birthplace New York

14. Maiden name Catherine Goulden
15. Birthplace Penna

16. Informant wife: Mrs. Pauline Ryan
Address 3827 37th Pl., Cottage City, Md.

17. Burial Date thereof. 2-25-48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va.

18. Funeral director W.W. Chambers Co. PFK

Address 517 11th S. E. Washington, D.C.

19. 2-21 48 Mary C. Patterson

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Cottage City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3927 37 th Pl.

(If rural, give LOCATION)

2.(a) If veteran, name war Spanish-American

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 21 February 19 48 at 5:50A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 Febrary 19 48 to 21 Feb. 19 48

and that I last saw him alive on 21 February 19 48

Immediate cause of death Cerebral Hemorrhage

DURATION 12 hrs.?

Due to Generalized Arteriosclerosis

Indef.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry R. Cooper M.D. or other

Address U.S. Naval Hospital, Bethesda, Md. Date signed 2/21/48

RECEIVED
FEB 26 1948
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, write the causes of death clearly and legibly. It is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12795

01848

CERTIFICATE OF DEATH

1796

216

Reg. Dist. No.

1. PLACE OF DEATH:

County MONTGOMERY

City or town Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred Suburban Hosp
8600 Old Georgetown Rd., Bethesda, Md.

How long in hospital or institution?

3. (a) FULL NAME

William F. Ryder

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Sept. 4, 1901

8. AGE:

Years

Months

Days

If less than one day

46

4

30

hrs. min.

9. Birthplace

Washington D.C.
(Town, county, and state)

10. Usual occupation

CLERK - RETIRED

11. Industry or business

U.S. GOVERNMENT

MOTHER FATHER

F. J. Ryder

12. Name

Washington D.C.

13. Birthplace

Mary E. Barry

14. Maiden name

Washington D.C.

15. Birthplace

Mrs. Nell Chancery (sister)

16. Informant

Address 1909 STRATTON RD - SILVER SPRING.

17. BURIAL

(Burial, cremation, or removal. Which?)

Date thereof FEB - 6 - 1948
(month) (day) (year)

Cemetery or crematory M T OLIVET

Location WASHINGTON D.C.

18. Funeral director

ElDame & Pennington Inc.

Address SILVER SPRING MD.

19. 2/7/48 (Date rec'd by registrar)

Mrs E. Jobe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1909 Stratton Rd

(If rural, give location)

2. (a) If veteran, name war

3. (b) Social Security Number

No

MEDICAL CERTIFICATION

Feb-3,

19 48 745 PM

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Dep med Senior care
and that I last saw h alive on

Immediate cause of death

Phos. tartaric prising
accident

Due to

Due to

Other conditions

Acute alcoholism

DURATION

2 days

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of 2-1-48

Where did injury occur

(City or town) Silver Spring (County) Montgomery (State) MD

Injured at home, farm, industry, public place (where?) home

Means of injury Phos. tartaric prising Intend at work

Frank J. Borchard M.D.

Dafford Gray M.D. or other

Gardiner Smith Date signed 2-4-48

Address



PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01849

1298

CERTIFICATE OF DEATH

Reg. Dist. No. 223-

1. PLACE OF DEATH:

County Maryland CountyCity or town Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 days 15 hrs 40 min

Hospital, institution, or street address where death occurred:

Washington Gen. Hospital, Takoma ParkHow long in hospital or institution? 19 days 15 hrs 40 min

3. (a) FULL NAME

Mrs Katherine Shoemaker.

4. Sex

5. Color or race

6. (a) Single, married, widowed or divorced

F. white

6. (b) Name of husband or wife

Blair Shoemaker.

7. Birth date of deceased (mo., day, yr.)

6. 1878

8. AGE:

Years	Months	Days	If less than one day	
69	4	7	9	hrs. 10 min.

9. Birthplace

Washington D.C.

(Town, county, and state)

10. Usual occupation

Clerk.

11. Industry or business

Federal Housing.

MOTHER FATHER

12. Name Roland F. Crome Wm.

13. Birthplace

New York City.

14. Maiden name

Lillian Kramer.

15. Birthplace

Washington D.C.

16. Informant

Hospital Record.

Address

Washington Gen. Hosp. I.P.

17. (Burial, cremation, or removal. Which?)

Burial.

Date thereof

2/17/48

(month) (day) (year)

Cemetery or crematory

GLENWOOD

Location

WASHINGTON - D.C.

18. Funeral director

The S.H. THINES Co.

Address

2901-147th St. N.W.

19. Date rec'd by registrar

Feb 14 1948

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C.

County

City or town Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1841 Columbia Rd. N.W.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

2-14-1948

19 48 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/6/4819 48 to 2/14 19 48and that I last saw her alive on 2/14 19 48

19 48

Immediate cause of death

acute diffuse peritonitis -
(hemorrhage)

7 days

Due to Biliary fistula -

8 days

Due to Cholecysto-renal fistula -

years

Other conditions

Ch. diffuse hepatitis -

years

(Include pregnancy within 3 months of death)

Major findings of operations

Cholecysto-renal fistula -Date of op 2/6/48

Autopsy results

as above -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

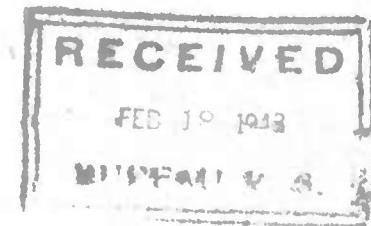
Injured at work?

23. SIGNATURE

John H. Broome, M.D.

or other

Address Takoma Park - Md.Date signed 2/14/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01850

CERTIFICATE OF DEATH

Reg. Dist. No.

223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct case.
is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County

Montgomery County

City or town

Gaithersburg Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 2-3-48

Hospital, institution, or street address where death occurred:

Wash. Hosp. & Hospital

How long in hospital or institution? Since 2-3-48

3. (a) FULL NAME

John William Sickerd Jr

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male white married

6. (b) Name of husband or wife John Catherine Sickerd

7. Birth date of deceased (mo. day, yr.)

6-7-98

6. (c) If alive, give age 48 years

8. AGE:

Years
49Months
9Days
10If less than one day
hrs. min.

9. Birthplace

Baltimore

(Town, county, and state)

10. Usual occupation

Baker

11. Industry or business

John Wm Sickerd

MOTHER FATHER

Germany

13. Birthplace

Punkowitz

14. Maiden name

Germany

15. Birthplace

Germany

16. Informant

John Catherine Sickerd

Address

4806 Byers St. E.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb 20-1948

(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

Suddard Maryland

18. Funeral director

Arthur E. Simmons Jr

Address

2007 Nichols Ave. 18th St. N.E.

19. Date rec'd by registrar

Feb 18 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Wash D.C. County

City or town (If outside city or town limits, write RURAL and give nearest town)

Street No. 4806 Byers St. E.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 17 1948 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 3 1948 to Feb. 17 1948

and that I last saw him alive on

Immediate cause of death
Carcinoma of
Colon with metastasis
to regional nodes + liver

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations As above

Date of op. 2-13-48

Autopsy results Fat necrosis due to obstructed duct

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

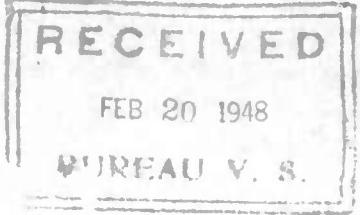
Injured at work?

23. SIGNATURE

Herman D. Slatz, M.D.

M. D. or other

Address 700 Brina St. ALEX., Va. Date signed 2-18-48



RECEIVED

FEB 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 223

01852

Spicer

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, institution, or street address where death occurred:
13 Poplar Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County Dist. of Col.
City or town 7115 9th St. N. W.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Washington D. C.
(If rural, give LOCATION)

3. (a) FULL NAME
James Albert Spicer

3. (b) Social Security Number

4. Sex Male	5. Color or race White	6.(a) Single, married, widowed, or divorced Widowed
-------------	------------------------	---

6.(b) Name of husband or wife Virginia H. Spicer

7. Birth date of deceased (mo., day, yr.) May 14, 1844

8. AGE: Years 103	Months	Days	If less than one day hrs.	min.
-------------------	--------	------	---------------------------	------

9. Birthplace Rappahannock Va.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Father Samuel S. Spicer
13. Birthplace Culpepper Va.

14. Maiden name Mother Nancy Teabill
15. Birthplace Va.

16. Informant Elliott Spicer
Address 7115 9th. St. N. W.

17. Burial Date thereof 2/12/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Walkers Chapel
Location Madison Co. Va.

18. Funeral director Deal Funeral Home
Address 4812 Georgia Ave N. W. D. C.

19. (Date rec'd by registrar) Feb. 10, 1948
Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 4 1948 at 9:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that Deceased from Aug 12 1947 to Feb 9 1948

and that I last saw h.e. in alive on Feb 9 1948

Immediate cause of death Acute Cardiac Failure

Due to Arterio-Sclerotic Heart Disease

Due to Generalized Arterio-sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

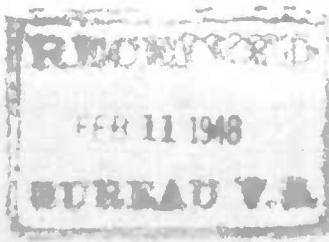
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dean H. Harding M.D.

M. D. or other
Address 113 Carroll St NW Date signed 2-9-48
wash DC



I

PLEASE WRITE PLAINLY, WISH UNFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

01853

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

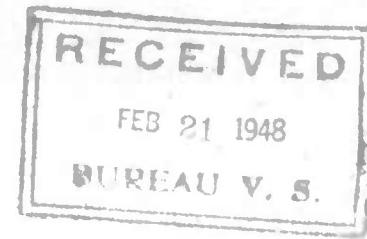
1. PLACE OF DEATH:
 County Montgomery
 City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs
 Hospital, Institution, or street address where death occurred:
7414 Wisconsin Avenue,
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State Virginia County Fairfax
 City or town Fairfax, Virginia
(If outside city or town limits, write RURAL and give nearest town)
 Street No. 3712 Valley Drive Park,
(If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME Hugh E. Spittal

3. (b) Social Security Number 161-18-7760

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>		
6.(b) Name of husband or wife <u>Gladys Dentler Spittal</u>				
6.(c) If alive, give age <u>?</u> years				
7. Birth date of deceased (mo., day, yr.) <u>August 24, 1908</u>				
8. AGE: <u>38</u>	Years <u>38</u>	Months <u>5</u>	Days <u>19</u>	if less than one day <u>hrs. min.</u>
9. Birthplace <u>Dravosburg, Pennsylvania</u> (Town, county, and state)				
10. Usual occupation <u>Employee-Army Map Service</u>				
11. Industry or business <u>None</u>				
12. Name <u>James Spittal</u>				
13. Birthplace <u>Unknown</u>				
14. Maiden name <u>Ruth N. Davies</u>				
15. Birthplace <u>Wales</u>				
16. Informant <u>Gladys D. Spittal (wife)</u>				
Address <u>Park Fairfax, Virginia</u>				
17. Burial (Burial, cremation, or removal. Which?) <u>Cemetery Biglerville, Pennsylvania</u>			Date thereof <u>Feb. 17, 1948</u> (month) (day) (year)	Date of op.
Location <u>Pennsylvania</u>				
18. Funeral director <u>Wm. F. Ludden Humphrey</u>				
Address <u>Bethesda, Maryland</u>				
19. <u>2/15/48</u> <u>Wm E Jolles</u> (Date rec'd by registrar)				
Registrar				
MEDICAL CERTIFICATION				
20. DATE OF DEATH <u>February 13th, 1948</u> at <u>7:15 P.M.</u>				
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19. to 19. and that I last saw h. . . . alive on 19.				
Immediate cause of death DEP. MED. EXAM. CASE: <u>Died Suddenly</u>				
DURATION				
Due to <u>Coronary occlusion</u>				
Due to				
Other conditions				
(Include pregnancy within 3 months of death)				
Major findings of operations				
Autopsy results				
PHYSICIAN: Please underline the cause to which death should be charged statistically.				
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide. Date of				
Where did injury occur? (City or town) (County) (State)				
Injured at home, farm, industry, public place (where?)				
Means of Injury Injured at work?				
23. SIGNATURE <u>Frank J. Borschart M.D.</u>				
Dep. Med. Exam. M. D. or other				
Address <u>Gaithersburg, Md.</u> Date signed <u>2/14/47</u>				



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. True correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01854

159

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County

Montgomery

City or town

Silver Spring, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

1 1/2 HRS.

Hospital, institution, or street address where death occurred:

Washington Sanitarium

How long in hospital or institution?

1 1/2 HRS.

3. (a) FULL NAME

Baby Strickland

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Male

White Single

6.(b) Name of husband or wife

None

7. Birth date of deceased (mo., day, yr.)

23 FEB. 1948

8. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day

0 0 0 2 hrs. 6 min.

9. Birthplace

Silver Spring, Maryland

(Town, county, and state)

10. Usual occupation

Infant (newborn)

11. Industry or business

12. Name

Harold Wade Strickland

13. Birthplace

Silver Spring, Maryland

14. Maiden name

Ellen Smith Strickland

15. Birthplace

Takoma Park, Maryland

16. Informant

Harold Wade Strickland

Address

8718 Cameron St. Apt 815

17. Burial

Cremation Date thereof 2/24/48

(Burial, cremation, or removal, Which?)

(Month) (day) (year)

Cemetery or crematory

Washington Sanitarium

Location

Takoma Park, Md.

18. Funeral director

Washington Sanitarium

Address

Takoma Park, Md.

written consent of parents

19. Date rec'd by registrar

Feb. 24, 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Montgomery

City or town

Silver Spring

Street No.

8718 Cameron St. Apt 815

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 23 Feb.

1948, at 10 AM

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from

23 Feb., 1948 to 23 Feb., 1948

and that I last saw h. m. alive on 23 Feb., 1948

Immediate cause of death

Prematurity

Duration

2 HRS.

6 min.

Due to

Spontaneous Birth at 24 1/2 weeks Gestation

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, list in the following:

Accident, suicide, or homicide

Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

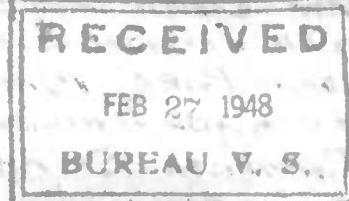
Means of Injury

Injured at work

23. SIGNATURES L Marshall Gwinning Jr. M.D.

M. D. or other

Address 8648 Georgia Ave. Date signed 24 Feb. 48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In case of death, physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

01855216
Reg. Dist. No.

1. PLACE OF DEATH:

County... Montgomery

City or town... Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Sudden death

How long in above place of death? Sudden death

Hospital, Institution, or street address where death occurred:

109 Leland Street,

How long in hospital or institution? None

3. (a) FULL NAME

Fred Wallace Thurston

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife Mary Noble Thurston

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.)

June 13, 1881

8. AGE:

Years 66

Months 66

Days 8

If less than one day

..... hrs. min.

9. Birthplace

Iowa

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

None

MOTHER FATHER

12. Name Unknown-Thurston

13. Birthplace Iowa

14. Maiden name Carrie Unknown

15. Birthplace Iowa

16. Informant Mrs. F. W. Thurston

Address Chevy Chase, Maryland

17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof Feb. 21, 1948

(month) (day) (year)

Cemetery or crematory Cedar Hill Crematory

Location Washington, D. C.

18. Funeral director WM. L. Anderson

Address Bethesda, Maryland

19. *S. J. 21 1948*

(Date rec'd by registrar)

Registrat

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montgomery

City or town... Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No... 109 Leland Street,

(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21, 1948 at 8:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on

Immediate cause of death

DEP. MED. EXAM. CASE

Due to Coronary occlusion

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

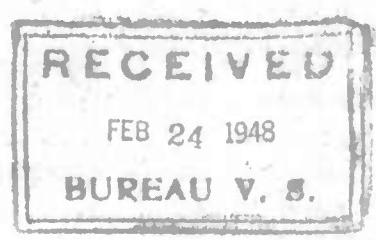
Frank J. Broschart M.D.

Dep. Med. Exam.

Address Gaithersburg, Md.

M. D. or other

Date signed 2/21/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01856

214

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Montgomery
City or town Silver Spring

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, Institution, or street address where death occurred:

215 Williamsburg Dr, Silver Spring

How long in hospital or institution?

3. (a) FULL NAME

Ostelle Remey Lorsch

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

WidowedB. (b) Name of husband or wife Joseph Lorsch

7. Birth date of deceased (mo., day, yr.)

17 Feb. 1862B. (c) If alive, give age dead years

8. AGE:

Years
85Months
11Days
22If less than one day
hrs. min.

9. Birthplace

Westtown New York

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Unknown

MOTHER FATHER

12. Name

Unknown

13. Birthplace

II

14. Maiden name

II

15. Birthplace

II

16. Informant

Mrs. F. StraderAddress 215 Williamsburg Dr, Silver Spring17. Burial + Cremation, or removal, Which? Feb. 11, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory UnionvilleLocation Unionville, Orange Co., N.Y.18. Funeral director Maxine E. Pumphrey
S.C.P.
Address Silver Spring, Md.19. Date rec'd by registrar Feb. 10 1948
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State New York County OrangeCity or town Unionville (If outside city or town limits, write RURAL and give nearest town)Street No. — (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Feb. 1948 at 7 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Feb. 1948 to 10 Feb. 1948and that I last saw her alive on 7 Feb. 1948

Immediate cause of death

Cardiac decompensation

DURATION

302 4m

Due to

Due to

Other conditions

Senility
Cerebralclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

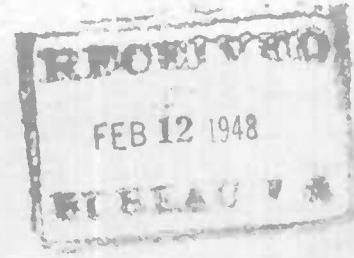
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE William D. And M.D. M. D. or otherAddress Silver Spring Md. Date signed 10 Feb 48



P.C.
Evidence for change
of age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01857

Form No. G 114 MAR 16 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 2-3-48Hospital, Institution, or street address where death occurred: Suburban Hosp.
8600 Old Georgetown Rd. Bethesda Md.How long in hospital or institution? Since 2-3-48

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County _____City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 8902 Old Bladensburg Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Carroll Lee Turner3. (b) Social Security Number
214-03-9437

4. Sex

Male	5. Color or race <u>White</u>	6.(a) Single, married, widowed, or divorced <u>Married</u>
------	----------------------------------	---

8.(b) Name of husband or wife

Helen Turner

7. Birth date of deceased (mo., day.)

Nov 17th, 1899

6.(c) If alive, give age years

8. AGE:

Years <u>48</u>	Months <u>0</u>	Days <u>14</u>	It less than one day hrs. min.
--------------------	--------------------	-------------------	--------------------------------------

9. Birthplace

Montgomery Co., Md.
(Town, county, and state)

10. Usual occupation

Maintenance Supt.

11. Industry or business

Preston Wire Constr. Co.

MOTHER FATHER

12. Name Frank Turner

13. Birthplace

Montgomery Co.

14. Maiden name

Liza Clark

MOTHER FATHER

15. Birthplace Montgomery Co.16. Informant MRS. HELEN E TURNERAddress 8902 Old Bladensburg Rd.

17. BURIAL

(Burial, cremation, or removal. Which?) Burial Date thereof Feb 9th 1948
(month) (day) (year)Cemetery or crematory Rock CreekLocation Washington, D.C.18. Funeral director Warren & Pumphrey - m.Address SILVER SPRING - Mo19. 2/8 1948 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-61948 at 5⁰⁰A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec

1947 to

to Feb

1948

and that I last saw him alive on 5 Feb 1948

Immediate cause of death

Pneumonia, lobar, cause undetermined

DURATION

6 days

Due to

Due to

Other conditions

Fibrilis of left lung

7.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

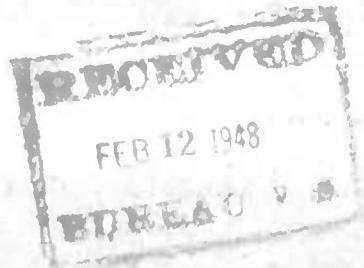
Means of injury

Injured at work?

23. SIGNATURE William D. Auld, M.D.

M. D. or other

Address Silver Spring, Md. Date signed 6 Feb 48





I PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age. Is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01859

108
212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Rural Seneca

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

HARRIET ANN WARD

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

F. col. widow

6. (b) Name of husband or wife

Charles Ward

6. (c) If alive, give age years

1861

7. Birth date of deceased (mo. day, yr.)

57

Years

Months

Days

If less than one day

hrs.

min.

8. AGE: 959. Birthplace Damascusville Montgomery Md.
(Town, county, and state)

10. Usual occupation

midwife

11. Industry or business

John Conley12. Name Maryland U.S.A.13. Birthplace Maria Johnson14. Maiden name Maryland U.S.A.15. Birthplace Maryland U.S.A.16. Informant Maryland Beckwith (daughter)Address Seneca, Md.17. Burial Seneca Date thereof 2/15/48
(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory SenecaLocation Seneca Md.18. Funeral director Permanence of DeathAddress Polymerite19. (Date rec'd by registrar) Feb 14 1948 Charles H. G.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

MontgomeryCity or town Rural Seneca

(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 2

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

Moan

MEDICAL CERTIFICATION

20. DATE OF DEATH 12 February 1948 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that attended deceased from

1.0 February 1948 to 11 Feb. 1948and that I last saw her alive on 11 Feb. 1948

Immediate cause of death

congestive heart failure

DURATION

3 daysDue to pneumonia, Lobar, Bilateral10 daysDue to debility + extreme old age (4/14/48)20 yrs.

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

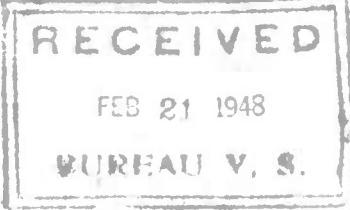
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE John S. Fawcett M.D. M. D. or otherAddress P.O. Box 14, Seneca, Md. Date signed 12 Feb. 48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01860
1248

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
 County Montgomery
 City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)
16 yrs.

How long in above place of death?

Hospital, institution, or street address where death occurred:
9311 Montgomery Avenue,

How long in hospital or institution?
None

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)
 Street No. 9311 Montgomery Avenue,

(If rural, give LOCATION)
 2.(a) If veteran, name war None

3. (a) FULL NAME

Betty B. Weadon

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Dr. F. Mason Weadon

7. Birth date of deceased (mo. day. yr.) November 28, 1906

6.(c) If alive, give age 49 years

8. AGE: Years 41 Months 2 Days 8 If less than one day

hrs. min.

9. Birthplace Philadelphia, Pennsylvania
 (Town, county, and state)

10. Usual occupation Housewife
 None

11. Industry or business

12. Name C. Howard Baily
 13. Birthplace Pennsylvania

14. Maiden name Unknown
 15. Birthplace Pennsylvania

16. Informant Dr. F. Mason Weadon
 Address Chevy Chase 15, Maryland

17. Cremation Feb. 7th, 1948
 Date thereof Feb. 7th, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Hill Crematory
 Location Washington, D. C.

18. Funeral director Wm. L. Anderson, Pumpernerry
 Address Bethesda, Maryland

19. 2/17/48 2/17/48
 (Date rec'd by registrar) Wm E. Jobe
 Registrar

3. (b) Social Security Number
None

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1948 at 10:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 1947 to Feb 6 1948 and that I last saw her alive on Feb 6 1948

Immediate cause of death Cirrhosis of Liver

Due to unknown

Due to

Other conditions
 (Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Bradley D Hodges MD

M. D. or other

Address 3/3 W 15th Street Date signed 2/6/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 ✓

01861

CERTIFICATE OF DEATH

Reg. Diat. No.

216

1. PLACE OF DEATH:
County..... Montgomery
City or town..... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?..... 8 months, 26 days
Hospital, institution, or street address where death occurred: US Naval Hospital, Bethesda, Md.
How long in hospital or Institution?..... 8 months, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... D.C. County.....
City or town..... Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 310 D St., N.E.
(If rural, give LOCATION) WWI
2.(a) If veteran, name war.....

3. (a) FULL NAME
WILLIAMS, Primiano (n)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife..... Anna Williams

7. Birth date of deceased (mo. day, yr.) May 18, 1890
6.(c) If alive, give age..... years

8. AGE: Years	Months	Days	If less than one day
57	9	5	hrs. min.

9. Birthplace..... Italy
(Town, county, and state)

10. Usual occupation..... Pattern Maker

11. Industry or business..... U. S Navy Yard

FATHER	12. Name	WILLIAMS, ?	dec.
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MOTHER	13. Birthplace	Italy	
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	14. Maiden name	unknown	
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	15. Birthplace	unknown	
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18. Informant..... wife; Mrs. Anna Williams
Address 310 D St., N.E., Wash., D.C.

17. burial Date thereof..... 2-26-48
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory..... Cedar Hill

Location..... Wash., D.C.

18. Funeral director..... Lee Funeral Home
Address Penn. Ave., S.E., Wash., D.C.

19. 2-24 1948
(Date rec'd by registrar) Mary C. Patterson
Signature _____
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... 23 February 1948 at 7:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
5-27-1947 to 2-23-1948
and that I last saw him alive on Feb. 23 1948

Immediate cause of death..... pneumonia & bronchitis -
Duration 14 days

Due to.....

Due to.....

Other conditions..... Carcinomatous due to
Carcinoma of Colon
(Include pregnancy within months of death) 3 years

Major findings of operations.....

Date of op. _____

Autopsy results..... Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of _____

Where did injury occur? (City or town) (County) (State)

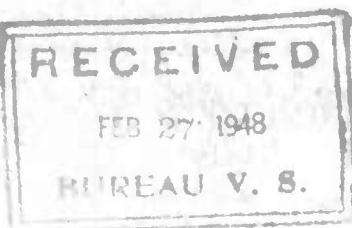
Injured at home, farm, industry, public place (where?)

Means of injury _____ Injured at work?

Witnessed by _____

23. SIGNATURE..... W. T. HARRISON, Lt. MC USN
M. D. or other _____

Address USNM Bethesda, Md. Date signed 2-24-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01862

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County..... Montgomery

City or town..... Bethesda (rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 1 month, 3 days

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?..... 1 month, 3 days

3. (a) FULL NAME

YOUNG, George Andrew

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

Col.

widowed

B. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) November 4, 1874

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

73.

3

15

hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

Ret. Stewart

11. Industry or business

12. Name Andrew Young dec.

13. Birthplace Mo.

14. Maiden name ARABELL, Addie dec.

15. Birthplace Mo.

16. Informant niece: Mrs. Tulip Peck

Address 315 Elm St., N.W., Wash., D.C.

17. burial

(Burial, cremation, or removal. Which?) Date thereof Feb. 24, 1948

(month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director Robert G. McGuire

Address 1820 9th St., N.W., Wash., D.C.

19. 2-19

19. 48

Mary C. Patterson

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... D.C. County.....

City or town..... Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 315 Elm St., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war Sp. AM.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 19

19. 48 at 7:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 January 19. 48 to 19 February 19. 48

and that I last saw him alive on 19 February 19. 48

Immediate cause of death

Chronic Nephritis

Due to Hypertensive Heart Disease

Due to

Other conditions Bronchopneumonia and Arteriosclerosis, Generalized

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Confirmed above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. E. MARLAND, Jr. Lt. JG MC USN

M. D. or other

Address USNH Bethesda, Md. Date signed 2-19-48

